C4675

Ack. 6th June, 1953

Miss Peck

CITY OF ABERDEEN.

REPORT

BY THE

MEDICAL OFFICER OF HEALTH

FOR THE YEAR

1952

4/6/53

CITY OF ABERDEEN.

REPORT

BY THE

MEDICAL OFFICER OF HEALTH

FOR THE YEAR

1952

ABERDEEN:
PRINTED BY G. CORNWALL & SONS.

MCMLIII.

CITY OF ABERDEEN.

SUMMARY OF STATISTICS.

The following is a summary of the principal statistics for the years 1947-52:—

	1947.	1948.	1949.	1950.	1951.	1952.
Population estimated to middle of year	187,751	188,853	189,314	187,961	183,248	183,626
Marriage-rate per 1,000 population .	11·1	11·1	9·7	9·9	10·0	10·5
Birth-rate per 1,000 population . .	22·0	19·1	17·5	17·2	16·5	16·5
Illegitimate birth-rate per 100 births .	5·9	5.9	5·7	5·3	5·4	5·7
Still-birth rate per 1,000 total births .	25	27	19	22	21	18
Infant mortality rate per 1,000 live births	64	34	30	29	27	30
Neo-natal mortality rate per 1,000 live births	26	20	16	17	18	18
Death-rate per 1,000 population . .	11·9	11·1	11·7	12·1	11·9	11·7
Malignant diseases death-rate per 1,000 population	1·77	1·69	1·82	2·08	1·95	2·28
All tuberculosis death-rate per 1,000 population	0·41	0·37	0·35	0·23	0·22	0·22
Respiratory tuberculosis death-rate per 1,000 population	0·35	0·33	0·32	0·20	0·20	0·20
Principal epidemic diseases death-rate per 1,000 population	0·07	0·05	0·06	0·09	0·08	0·03
Average age at death (in years) . .	57·3	61·7	64·1	61·9	65·7	64·6

PREFACE.

In submitting the Annual Report dealing with the health of the City and the activities of the Health and Welfare Department during 1952, I am in the happy and rather unusual position of being able to comment favourably on the services without any risk of being accused of indirect self-praise. It might be difficult to apportion credit between the Corporation as a whole, the Convener and members of the Health and Welfare Committee, Dr. H. J. Rae (who retired from the post of Medical Officer of Health on 30th September), and the other members of the health team; but it is at least obvious that, since I was Medical Officer of Health for only the last three months of 1952, my responsibility is merely for the writing of the report, not for the work which it records.

It will be noted that the general lay-out is altered, and that information is given in more detail than the report for any recent year. An explanation may therefore be desirable. In many large burghs and counties there was a tendency during the war and post-war years for annual reports to be curtailed to the absolute minimum. This tendency was understandable enough in view of shortages of staff on the one hand and increasing cost of printing on the other, but it gradually produced in at least some counties and towns a highly unsatisfactory situation—in which the ratepayers had no available adequate account of services on which a portion of their money had been spent, councillors had scanty evidence on which to determine whether their health services were functioning efficiently, a medical officer of health might find himself debarred by sheer shortage of space from carrying out his duty to draw attention to any matters adversely affecting health in his area, and the supervisory and advisory functions of the Central Government Department were made increasingly difficult by lack of local information. In order, presumably, to eradicate this tendency to undue brevity, the Department of Health for Scotland have issued a circular calling for a more extensive report for 1952, and setting out in considerable detail matters that should be included in the report.

The present report follows the lines suggested in the circular. Indeed, about the only portion not expressly requested by the Department of Health for Scotland is the chapter on background data; and the need for that chapter is too obvious to require explanation.

The Department of Health for Scotland have also asked that each medical officer of health should indicate to what extent his Council have as yet managed to implement the recommendations contained in an official report entitled "What local authorities can do to promote health and prevent disease"; and that he should comment freely on the working of the National Health Service. As a matter of convenience, this preface is therefore divided into four parts: the first deals with health statistics and health services generally; the second discusses the extent to which the recommendations of the Scottish Health Services Council have been implemented; the third offers a few comments on the working of the National Health Service; and the fourth refers to the grave problems of staff shortages and staff sickness.

HEALTH STATISTICS AND HEALTH SERVICES.

MATERNITY AND CHILD WELFARE.

Healthy children are the most valuable asset that any community can possess, and, in any review of health services, pride of place must be accorded to those affecting children.

Judged as a whole, the **Maternity and Child Welfare Services** of Aberdeen are excellent. Their quality is perhaps best indicated by a brief consideration of the rates of maternal mortality, still-births, and infant deaths. A **maternal mortality rate** of 0·6 per thousand total births (or a figure of only two deaths during the year) is obviously approaching the irreducible minimum; and, in point of fact, neither of the women who died had sought ante-natal care from clinic or hospital or general practitioner. Again, a **still-birth rate** of 18 per thousand total births is quite unusually low. The suggestion is made in the appropriate section of the report that factors of importance in reducing the number of still-births include good co-operation between clinical consultants and medico-social experts at ante-natal clinics and the attendance of nearly 90 per cent. of expectant mothers at these clinics.

The **infant mortality rate** of 30 per thousand live births is five below the average for Scotland but two above the average for England and Wales. It must, of course, be remembered that Aberdeen has a higher proportion of persons in the economically lowest social class than have most other cities; that it had a moderate amount of unemployment in 1952 (*e.g.*, 4·1 per cent. of all males on one unselected date); that it has a good deal of overcrowding; and that it compares unfavourably with the other principal cities of Scotland in the proportion of households lacking piped water supplies, water closets, kitchen sinks, and cooking facilities. Again, Aberdeen has a continuing social problem in that the illegitimate birth-rate is high, and is indeed tending to rise over the last three years. In view of all these things, an infant mortality rate of 30 can certainly not be regarded as unsatisfactory.

Nevertheless, there were 57 still-births, 90 infant deaths, 13 deaths of children aged 1-4 years, and 17 deaths of school children, a total loss of 177 young lives which cannot but constitute a challenge to the Health and Welfare Department. Even in monetary terms, if one assumes that each child, had he survived, would have later earned as little as £5 a week for a matter of 40 years, the 177 young deaths represent a loss of earning power of over £1,750,000.

As services improve, it becomes more necessary to think in terms of **morbidity,** instead of simply mortality. The figures for school entrants certainly do not suggest that the health of young children is incapable of further improvement. It is, for example, a little alarming to find that one child in every sixty has a deformity classed as probably due to rickets. Again, for the last three years or so the incidence of **squint** in school entrants in Aberdeen has been abnormally high: this phenomenon is being made the subject of a special investigation in 1953.

While the maternity and child welfare services are already first class, it is possible to suggest ways in which they can become still better. First, there is a need for **more clinics,** although the introduction during the year of a **mobile clinic** (the first to be used for child welfare work in any Scottish municipality) may do something to meet the need. Too many babies at present cease to attend soon after they reach the age of one year; but the health visitors' task of persuading mothers to take advantage of the facilities provided is rendered more difficult if the clinics are already working to capacity. Again, clinics must be made **attractive** and kept attractive: the appointments system has greatly helped, and it may be that the provision of ultra-violet light units in more clinics would be useful; but the most essential point is good, up-to-date modern buildings, specifically designed and suitably situated — a matter, of course, of long-term policy. Yet again, there is a need for a considerable **extension of health education** and of the teaching of parentcraft: so many diseases nowadays are preventable, but so few are as yet prevented: but for this work it would be necessary to secure **more health visitors** and perhaps health visitors with a training even better and more prolonged than that at present given. By no means least, the services would benefit from the restoration of adequate **dental facilities** for expectant mothers and young children. There is need, too, for more **study of children** in their environmental, social, and emotional background, for only by such study can new information be gained about how diseases are caused. To wait till a disease has occurred and then undertake a retrospective enquiry is a course less likely to yield results. It is hoped that some such enquiries may be initiated in 1953.

SCHOOL HEALTH SERVICE.

In evaluating services that promote health and prevent disease, there is an inevitable tendency to look for reduction of deaths. Yet the value of the **School Health Service** is best shown not by the number of fatalities in the age-period, 5-14 years, but by the virtual eradication of diseases that were very common only a few years ago. For instance, nowadays **scabies** and **ringworm** each occurs about once per ten thousand pupils, and the incidence of **impetigo** is six per thousand. During the year, however, shortages of staff have continued to press hardly on the service. For these shortages, no blame attaches to the Corporation: the authorised complements of school doctors, dentists, and nurses might be adequate, but in each case the numbers employed are below the complement, and the obtaining of new recruits becomes steadily more difficult.

Apart from the curiously high incidence of squint in school entrants in recent years, the most disquieting features found at medical inspections of children were a continued rise in the proportion with **unhealthy mouths and**

teeth (from 1·1 per cent. in 1949-50 to 2 per cent. in 1950-51, and 2·6 per cent. now), and an unexplained increase in the prevalence of **diseases of the lung** (from 3 per cent. in 1949-50 to 3·9 per cent. in 1950-51, and 4·4 per cent. now). The percentage of children notified to parents as suffering from defects is also showing a gradual tendency to rise: 11·2 per cent. in 1949-50, 11·3 in 1950-51, and 11·7 in 1951-52.

It is pleasant to record that the Corporation has decided to appoint an **audiometrician** to carry out tests of hearing, although (since the report on the School Health Service covers not the calendar year but the school year 1951-52) the decision is strictly a matter for inclusion in next year's report.

MENTAL HEALTH SERVICE.

According to the Department of Health for Scotland, "At least 30 per cent. of patients who seek medical advice are suffering from disorders in which mental and emotional factors are of primary importance." The role of the **mental health service** in the prevention and even early diagnosis of mental, nervous, and psychosomatic diseases can therefore be one of great significance. Yet, in Aberdeen as in most places, the development of that service is essentially a matter for the future. At least it can be said that at the end of the year the problem of how best to expand the mental health service was being considered by the Health and Welfare Committee.

VACCINATION AND IMMUNISATION.

Aberdeen is in an unusual position in respect of **vaccination and immunisation.** In many towns and counties the vaccination figures are alarmingly low while those for immunisation against diphtheria are reasonably good, but here the situation is to some extent reversed. The statistics for **vaccination against smallpox** are about as satisfactory as one can expect: broadly, about seven children are vaccinated for every ten born. Credit is due to health visitors (who are unwearied in their efforts to remind every mother that smallpox can invade this country at any time), general practitioners (who perform fully three-fifths of the vaccinations), and medical officers at the clinics (who perform the remaining two-fifths).

Figures for **immunisation against diphtheria** are much less good: at the end of 1952 only 51 per cent. of pre-school children were recorded as having been immunised. Approximately one-third of children are immunised by general practitioners, another third are immunised at child welfare clinics, and the remaining third remain unimmunised until they enter school, most of them being then immunised by the school doctors. It must be emphasised that, while the giving of reinforcing injections after school entry is of the highest importance, it should be a rarity for a child to receive a primary course of immunisation as late as the age of five years. A child left unprotected till that age has been subjected for years to a serious and unjustifiable risk. Every effort will be made to improve the immunisation figures during 1953.

Figures for **whooping cough inoculation** are less good than for vaccination and approximate to those for immunisation against diphtheria.

As for **immunisation against tuberculosis,** this has so far been offered only to contacts of the disease : 333 persons were immunised during 1952.

TUBERCULOSIS AND INFECTIOUS DISEASES.

The incidence of **tuberculosis,** although far lower than in the south-west of Scotland, is not yet falling. Indeed, the number of notified cases in 1952 (208 respiratory and 27 non-respiratory) was higher than in the previous year. The prevalence of other **infectious diseases** was fairly low: there were, for example, 801 intimated cases of measles, 549 cases of whooping cough, 314 of scarlet fever, 10 of enteric fever. 18 of poliomyelitis, 14 of dysentery, and 3 of diphtheria.

CARE AND WELFARE OF THE ELDERLY.

During the year there have been considerable developments in the Corporation's **services for the elderly.** The first two **residential homes** at Balnagask and Ferryhill Place had been opened at the end of 1950 and 1951 respectively ; and in 1952 a building adjacent to No. 3, Ferryhill Place was acquired (and will ultimately form part of an enlarged home) and a specially designed building was in course of erection at Northfield. There is, of course, a pressing need for the acquisition of other buildings as these become available and for the construction of other specifically designed homes.

Even more important than residential homes are **services designed to maintain the health of old people** who can then in many cases remain happily in their own houses. During the year a **chiropody** service was made available for unemployed old persons: by the end of December, 165 persons had received treatment, and the service had established itself as of the highest value. Although shortage of health visitors prevented full implementation of the policy of **visiting** old persons in their homes, 200 elderly people were actually being visited at the close of the year: by acting both as "health" visitors under the Corporation's schemes for prevention and after-care and as "welfare" visitors under the National Assistance Act, the health visitors have a better chance to become—or to remain—the trusted friends and advisers of the persons visited. Probably these visits can do more than any other single aspect of the service to promote the health and well-being of old people, and to ensure that persons in need of any particular type of assistance actually get it.

Another feature of 1952 was the creation, by the District Nursing Association at the instance of the Corporation, of a **night nursing service** which, although still in process of development in December, helped 175 persons during the year. Incidentally, it may be mentioned that 59 per cent. of the time of the home nurses on day duty and 78 per cent. of the time of night nurses was devoted to persons over the age of 65; and during the year **home helps** were made available for 225 such persons.

While it may well be that the health and welfare services for old people will expand vastly in the next few years, and indeed that sheer economic necessity will make it imperative that communities pay increased attention to preventing disease and maintaining health in persons in the elderly seventh of the population, it can at least be said that the services in Aberdeen have already made a good start.

CRIPPLES.

PREVENTION, CARE, AND AFTER-CARE.

Schemes for the more adequate provision of facilities for the health and welfare of **cripples** and other handicapped persons were being drafted at the close of the year; and the question of whether the time was ripe for a revision of the scheme for **prevention, care, and after-care** was also under review.

A YARD-STICK FOR THE HEALTH SERVICES.

In 1951 the Standing Advisory Committee on Local Authority Services produced a report entitled "What local authorities can do to promote health and prevent disease." In the belief that local health authorities themselves sometimes failed to appreciate fully the significance and amplitude of the contribution they could make to health and well-being, the Department of Health for Scotland issued copies of the report to all local health authorities, and the hope was expressed that the report might "be read and considered, not only by professional workers in the field of public health, but also by the elected representatives of the community." The avowed intention was to stimulate local authorities "to provide both the epidemiological and social services that are needed"; but the report can also be used as a yard-stick against which to measure the services provided by an authority. It is presumably because of this that the Department of Health for Scotland now seek information about the extent to which the recommendations have been—or are being—implemented.

Probably the easiest way to provide the information is to summarise the main recommendations and deal with each in turn.

CO-ORDINATION.

(*a*) **"The health committees of local authorities . . . should take the lead in co-ordinating preventive services."** Before the publication of that report, a useful step was taken in Aberdeen by the amalgamation of the Health and Welfare Departments: the advantages of this combination are discussed in the appropriate portion of this annual report. Other steps were the setting up of a Joint Advisory Committee on Health Services, containing representatives of the Regional Hospital Board, the Executive Council, and the Local Authority; of another Joint Committee, representative of statutory and voluntary bodies, to deal with problems of children neglected in their own homes; and of an Old People's Welfare Joint Advisory Committee. In addition, there has been a great deal of co-operation between officials, among whom there exists a spirit of mutual tolerance and goodwill.

Yet more than goodwill is required for full co-ordination of services: further co-ordination may perhaps depend partially on additional legislation to ensure, for example, that each branch of the health service is under an obligation to supply to the other branches any information which they may reasonably request. In particular, if the main duty of a Medical Officer of Health

> "is to study all factors affecting the health of the community, and —without neglecting the remaining infectious diseases—to apply to other health problems the epidemiological and other methods which yielded such striking results in reducing infections" (paragraph 6 of the report),

he must, for the discharge of that duty, be provided with information about the occurrence of diseases and about the discharge of patients from hospital.

DEATHS FROM INFECTION.

(*b*) "**Preventive measures can still do a great deal to reduce deaths from infection**"; ten diseases are picked out as causing deaths. In Aberdeen, **diphtheria** is effectively prevented by immunisation, although at present the proportion of children immunised is not as high as it ought to be; **immunisation** has been begun against **whooping-cough;** health education and campaigns for food hygiene have already done much to reduce **typhoid and paratyphoid** to rarities and to diminish **dysentery,** though undoubtedly there is room for much further action in this field; attention to milk has almost eliminated **non-respiratory tuberculosis** as a cause of death; and health education is slowly reducing the incidence of **venereal diseases. Measles** is not yet preventable under normal circumstances, but, during the outbreak in the late autumn of 1952, parents were publicly warned by the Medical Officer of Health to regard measles as a dangerous disease and to seek medical advice as soon as the rash appeared: by early and effective treatment most complications should be avoided. For the prevention of **poliomyelitis,** little can as yet be done although American attempts to produce a vaccine appear to be on the verge of success. As for **respiratory tuberculosis,** much is being done to limit its prevalence and to reduce the severity of individual cases—by careful follow-up of known contacts (to identify and isolate the person who spreads the disease, and to enable him to be treated before the disease is advanced), attempts to decrease overcrowding, education on such topics as diet and ventilation, and so forth. Also, at the end of the year, a plan for offering immunisation to children aged 14 years or over was being worked out.

The extent to which recommendations under this head are being implemented can be indicated by stating that, in 1952, there were 40 deaths from tuberculosis (13 under 45 years and 27 over that age), and 20 from all other infections (8 under 45 and 12 over that age).

STILL-BIRTHS AND INFANT DEATHS.

(*c*) "**Still births and infant deaths . . . There is no justification for thinking that maintenance of the present services is enough.**" It has been indicated earlier that Aberdeen has established a new low record still-birth rate and that the infant death-rate is satisfactory, but measures have been suggested that might further reduce both still-births and infant deaths: these measures, involving as they do additional use of health visitors and new buildings, must be a matter of long-term planning.

ACCIDENTS.

(*d*) "**The Medical Officer of Health and his staff are in a position to study all accidents**" and to apply epidemiological methods to their control. The two difficulties are—lack of staff and lack of information. Nevertheless, a study of home accidents has been begun.

RESPIRATORY DISEASES.

(*e*) "**Deaths from respiratory diseases . . . The educative influence of a progressive local authority can do much.**" Very little has been attempted as yet in relation to smoke abatement. As for pneumonia occurring as a complication of measles or whooping-cough, attempts are being made to ensure that parents realise the gravity of these diseases. It may be noted that 301 cases of primary pneumonia were notified in 1952, and it is suggested in the body of this report that pneumonia is probably under-notified.

GASTRO-ENTERITIS.

(*f*) "**Deaths from diarrhœa and enteritis**": encouragement of breast-feeding, anti-fly campaigns, and spraying of dustbins with insecticides are advised. Breast-feeding of babies is actively encouraged by all members of the Health and Welfare Department. The other measures suggested have not yet been put into operation in Aberdeen.

"These five groups ((*b*) to (*f*) above) represent the main causes of death in the first 45 years of life." It may be appropriate to mention that, in 1952, 12·4 per cent. of all deaths in Aberdeen were in persons under the age of 45 years.

ECONOMIC VALUE OF PREVENTIVE SERVICES.

(*g*) "**Prevention is cheaper, as well as better, than cure. In these days the nation cannot afford sickness.**" Every health worker will cordially agree that the productive worker in hospital for a week

> "not only costs the country something like £12 to £15 in hospital treatment, but also deprives the community of the value of the work which he would otherwise have done."

It is therefore imperative that a local health authority "should play a leading part in the campaign to improve physical and mental health." Every attempt is made to do so in Aberdeen, but it is fair to add that each attempt is hampered by lack of staff, and that at present there are strong financial inducements to young doctors to enter hospital or general practice and to young nurses to remain in hospital, rather than to specialise in prevention. This point will be further discussed later.

DEFECTS IN SCHOOL ENTRANTS.

(*h*) **Defects in school entrants could often be "prevented by better antenatal and child care."** This point has been discussed earlier in this preface.

SCABIES AND IMPETIGO.

(*i*) "**Probably the commonest skin diseases are scabies and impetigo, both of which are preventable.**" In Aberdeen these diseases are—with very few exceptions—prevented.

INVESTIGATIONS.

(*j*) "**For many conditions, further detailed study is necessary before measures of prevention are devised . . . Medical Officers of Health and their staffs are in a particularly favourable position for conducting such investigations.**" Studies of still-births have been carried out for some years; a study of home accidents was initiated in 1952; and it is hoped that other investigations will be commenced in 1953; but—as already mentioned—there are two basic difficulties, lack of staff and lack of information from other branches of the service.

STUDY OF SOCIAL AND OCCUPATIONAL FACTORS.

(*k*) "**Further studies, in which epidemiological methods would relate the incidence of such conditions to occupational and social factors, are tasks well suited to Medical Officers of Health, of course drawing upon the clinical divisions**

of the service for much of the necessary raw material." Rheumatism, peptic ulcer, and industrial health generally are instanced as examples. In Aberdeen it has not yet proved practicable to implement this recommendation.

AFTER-CARE.

(*l*) **"After-care is at present undertaken by most local authorities only in respect of tuberculosis. It should be developed also in respect of other diseases."** To a very limited extent it is now proving possible to supply after-care to elderly persons discharged from hospital. There is, of course, already evidence that, in places which have contrived to expand their after-care schemes to include patients suffering from diabetes or peptic ulcer, the proportion of such patients returning to hospital is greatly reduced. But once again, numerical shortages of staff constitute an overwhelming difficulty.

GERIATRIC INVESTIGATIONS.

(*m*) **"In the prevention or reduction of illness in the older section of the community, there is again much scope for investigation. For this the health departments of local authorities are specially well fitted to take the initiative."** Examples given are study of origin of diseases of old age, and effects of retirement. It has not yet proved possible to undertake such investigations in Aberdeen.

CARE OF THE AGED.

(*n*) **Care of old people—"arrangements for health advice by health visitors, control of home nursing, provision of home helps, consideration of special housing needs, provision of hostels, &c."** The extent to which these suggestions have been implemented has already been indicated.

RESEARCH ON SOCIO-ECONOMIC AND EMOTIONAL CAUSES OF DISEASE.

(*o*) **Promotion of mental hygiene by broadening research in environmental medicine "to include an enquiry into socio-economic and emotional factors."** No such enquiry has yet proved possible, but it is hoped to commence one during 1953.

TEACHING OF PARENTCRAFT.

(*p*) **"Instruction to parents in parent-child relationships."** This is not yet undertaken to any great extent.

GROUP DISCUSSIONS.

(*q*) **"Group discussion at child welfare clinics, &c."** Sessions are specifically allocated to health education at the various clinics, but there is room—and need—for very considerable extension.

THE HEALTH VISITOR'S TRAINING.

(*r*) **"It is clear that the health visitor is of key importance in the instruction of mothers . . . The education of health visitors, therefore, should include such subjects as normal psychological development, parent-child relationships, and the treatment of common behaviour disorders."** In so far as is possible within the limits of a prescribed syllabus of training, student health visitors in Aberdeen are already given some teaching on these matters.

THE HEALTH VISITOR AS TEACHER.

(*s*) **"The health visitor is an educator of supreme importance." "Health education . . . implies an appreciation of the changing scope of the modern medical technique,"** and, while trained teachers may lack the necessary knowledge, health visitors and other experts in preventive medicine may lack teaching experience. So far as is possible in an already overcrowded curriculum, student health visitors in Aberdeen are instructed in the technique of teaching.

STATISTICAL ENQUIRIES.

(*t*) "**Research and statistical enquiry . . . Local authorities should keep in view the new powers they have been given to promote research.**" It was with this in mind that the Corporation decided at the end of 1952 to appoint a part-time statistician, if one could be procured.

COMMENTS ON THE WORKING OF THE NATIONAL HEALTH SERVICE ACT.

THE BENEFITS.

The passing of the National Health Service (Scotland) Act conferred very real benefits on the people of the country. Lest it be thought that the criticisms offered below imply hostility to the Act as a whole, four points of particular value may be mentioned. Before 1948, many sick persons hesitated to summon a general practitioner through fear of being unable to meet the bill or through unwillingness to avail themselves of charity; the provision without direct charge of a **family doctor** for every member of the community was a tremendous advance. Similarly, before 1948, the **district nurse** was available only to those who could pay or would accept charity; the general increase in the numbers of home nurses employed is an indication of the size of the advance. Again, before 1948 the **health visitor** was concerned primarily with children; her translation into the trusted friend and health adviser of the whole family is a vast step forward. Equally important was the provision, as a background to these services, of a complete **Hospital and Consultant Service** without direct charge to the patient.

Yet the Act had its faults and imperfections, and these have been made greater by the fact that, in the development of the Service during the last 4½ years, certain sections of the Act have received undue prominence, while certain others have remained almost a dead letter. It would be possible to fill many pages with criticisms of the present functioning of the Service, but comment will here be deliberately restricted to ten points.

1. Quantitative and qualitative inadequacy of recruitment to the preventive health services.

FAILURE OF RECRUITMENT TO PREVENTIVE SERVICES.

Shortages of nurses, dentists, and doctors in the local authority services are grave and are tending to increase, mainly as a result of increasing financial disparities between these officers and their opposite numbers employed in other portions of the National Health Service. The nurse who undertakes additional full-time study to secure the health visitor's certificate is now rewarded for her hard work by a salary which is actually smaller than she would have received had she remained a ward sister and not taken the additional certificate. Moreover, her chances of promotion as a health visitor are much poorer than are the promotion prospects of a ward sister. The assistant medical officer (the career grade for two-thirds of the doctors who take a post-graduate diploma in public health and enter the local authority service) receives a salary maximum £600 below that of the senior hospital medical officer, and received much less than the taxable income of the average general practitioner even before the recent Danckwerts Award substantially increased the remuneration of general practitioners. It has, moreover, to be remembered that the training of the medical student and student nurse takes place largely in hospital, and that, to a youth at the beginning of his or her career, the hospital, with the glamour and excitement of the operating theatre, tends to appear more attractive than the less spectacular, although perhaps really more important, work of preventing disease. It is obvious that, unless both the quality and the quantity of recruits to the local health authority service improve, the preventive health services will inevitably decline, as they are already doing in some places; that the health of the community will suffer, as it is already beginning to do; and that the cost of treatment will grow. It may be suggested that one of the reasons why the cost of the treatment services is tending to expand year by year is the inadequate national development or even national maintenance of the preventive health services. Shortages of staff in Aberdeen are mentioned later in this preface.

2. Insufficient Research in Preventive and Social Medicine.

RESEARCH NEEDED.

The hospital physician sees patients whose diseases are already considerably advanced and his research must needs be largely into methods of treatment. An individual general practitioner sees a multitude of different diseases but few cases of any one disease and, since he is mainly concerned with treatment, such research as he carries out tends also to deal primarily with therapy. If the community is to be made healthy and if more diseases are to be prevented, it is essential that the third limb of the National Health Service undertakes its due share of investigation and research. The National Health Service (Scotland) Act has already laid on the local authority certain duties and responsibilities in regard to research into the causes and prevention of disease, and various official documents have drawn attention to the need for medical officers of health to study the epidemiology of non-infectious illnesses and accidents and to investigate socio-economic and emotional causes of illness. There seems no reason why such conditions as the anæmias, the pneumonias, peptic ulcers, and home accidents should not be as effectively prevented as are smallpox, typhoid, diphtheria, scabies, impetigo, scurvy, and rickets. For such research work, however, requirements include—

(*a*) Sufficient staff, including some persons of as high calibre as the best recruits to the other branches of the National Health Service;

(*b*) Access, under the bonds of confidentiality, to all sickness records, such access being preferably a matter of statutory provision;

(*c*) Financial encouragement to local authorities to undertake research work; and

(*d*) The provision of adequate statistical assistance and statistical machinery.

3. Insufficient Mental Health Services.

PROMOTION OF MENTAL HEALTH.

The national increase in the amount of mental and nervous illness is disquieting, particularly when studied in connection with increases in juvenile delinquency and crime. The adequate development of a mental health service is essential but as yet no local health authority has managed to create such a service. It must, of course, be understood that the type of medical officer with the knowledge and enthusiasm to build a service designed to promote mental health in the community and detect early deviations from normality could, in the hospital service, as a consultant in mental diseases, receive a salary of £2,750 and a distinction award. Hence, local health authorities are, right at the start, confronted with the extreme difficulty of getting people of the calibre required. Yet, because of the need for close collaboration with the education service on one hand and the welfare service on the other, a mental health service cannot be organised otherwise than by a local health authority.

4. Inadequacy of Services for the Elderly.

SERVICES FOR THE AGED.

There is need for a great deal of research into problems of ageing and diseases of later life. In addition, there is room for much application of knowledge that already exists. It may be mentioned here that there is no longer one individual charged by statute with the responsibility of ensuring that an elderly person's needs are really met. The Welfare Department, the Health Department (in local authorities where these two are separate), the general practitioner, the District Nursing Association, the Hospital Board, the National Assistance Board, and various voluntary bodies all come into the picture, and nobody has the power to co-ordinate these services. At present, no one is even charged with the duty of assessing the needs of an area in respect of services for old people: for it is manifestly impossible for different people to assess the needs in respect of hospital beds, of residential hostels, of special houses, of visitation by health visitors, and of home helps, all in complete independence of each other.

5. Danger of Poorer Control of Infectious Diseases.

INFECTIOUS DISEASES.

With the passing of the fever hospitals to Regional Boards, the gap between clinician and epidemiologist has widened. The consultant in an Isolation Hospital is becoming more and more a pure clinician, unconcerned with the spread of disease and the methods of limiting such spread; and the ability of the Medical Officer of Health to cope with epidemiological features may be deteriorating through lack of contact with actual patients. Possibilities include (*a*) the return of Isolation Hospitals to local authorities; (*b*) the appointment in each region of a Regional Epidemiologist; and (*c*) the appointment in each area of the Medical Officer of Health and, where necessary, one or more senior members of his staff as honorary consultants in infectious diseases and the allocation to them of some hospital beds. Probably the advantages lie with the last solution.

6. Deteriorating Control of Tuberculosis.

TUBERCULOSIS.

Tuberculosis is a preventable disease which should be prevented. The tuberculosis service has been split into two parts by the Act, and it has certainly never been generally accepted that division means strength. In Aberdeen, as in some other places, an attempt to remove the dichotomy has been made—the senior tuberculosis consultant of the Regional Board has the honorary rank of a deputy medical officer of health for tuberculosis and undertakes some preventive work, being assisted by health visitors seconded for that purpose from the local authority staff. While this makeshift functions reasonably well at present, it is very doubtful whether it will continue to work in the future because a new race of tuberculosis consultants is springing up, a race who lack the environmental background and preventive outlook of their predecessors.

7. Inadequate Application of Existing Knowledge to Prevention.

APPLICATION OF EXISTING KNOWLEDGE.

In order to prevent diseases for which there is already sufficient knowledge to make them preventable, a massive extension of health education is required. This extension demands not merely an increase in the number of health visitors but also a better training for student health visitors, more instruction in the psychology of child development, in parentcraft, in parent-child relationships, in sociological factors, in family budgeting, &c., and more instruction in the technique of teaching. Increase in the number of health visitors and increase in the length and thoroughness of their training would probably be the most rewarding development of the National Health Service that could at present be undertaken.

8. Inadequacy of After-Care Services.

AFTER-CARE.

At present—largely through shortages of staff—after-care services are virtually restricted to tuberculosis. It is manifest that extension of these services to selected diseases would greatly reduce sickness in the community and would lessen the number of patients who have to be re-admitted to hospital.

9. Inadequate Training of Doctors and Nurses in Preventive Methods.

TRAINING IN PREVENTIVE MEDICINE.

The training of medical undergraduates and of student nurses in the promotion of health and the prevention of disease remains grossly inadequate. There is as yet no general realisation that "hygiene" (to give it its old name) or "social health" (to use the modern phrase) is a subject no less important than "surgery" or "clinical medicine."

10. Overweighting of Committees with Consultants.

MEMBERSHIP OF COMMITTEES.

There is a tendency for national committees (like the Scottish Health Services Council and its advisory committees) and also for local committees (*e.g.*, Boards of Management) to be overweighted with practitioners of curative medicine and, in particular, with consultants. In a rapidly expanding science like medicine no doctor can hope to remain expert in lines divergent from his own. If, for example, an anæsthetist, a medical officer of health, and a surgeon have to express opinions on work which is within the province of one of the three, the other two will really speak as laymen but, because of their medical qualifications, may carry unmerited weight. It may perhaps be suggested that the system already used in local authority work might be extended to all such committees, namely, that doctors should attend as expert advisers on their particular subjects but should not be full members of the committees with voting power.

STAFF VACANCIES AND STAFF ILLNESSES.

Owing to lack of suitable candidates, a number of vacant posts remained unfilled throughout the year. These vacancies included three for medical officers (two of them advertised without success in each of the years 1949-51), three for dental officers (a fourth vacancy being filled in September), and 13 for health visitors. As in other health departments, shortage of staff is a grave and increasing difficulty, and is preventing the adequate development of the services.

Persistent shortages of staff caused increasing pressure on the persons employed in the department. The staff in general strove nobly to prevent these shortages from adversely affecting the health services provided for the community; but, in only too many cases, prolonged overwork produced the inevitable result—illness.

The amount of illness was particularly alarming among medical and dental officers, health visitors, and midwives, *i.e.*, among the very persons who, by reason of their knowledge of methods of promoting health and preventing disease, might, under normal circumstances, be expected to show a lower incidence of sickness than is found in the community at large. Short-term absences from work (1-4 days) were very numerous; and illnesses necessitating more than four days' absence occurred in six doctors, two dentists, one superintendent nursing officer, 18 health visitors (23 separate illnesses), and four midwives (five illnesses). Out of the 76 persons employed in the five categories just mentioned, 30 (or almost 40 per cent.) were absent from work for more than four consecutive days during the year, and lost 999 working days during these absences.

In other words, when short absences of under five days are excluded, the 76 persons in the five groups mentioned above lost a total of **three and a sixth working years** during 1952 through long-term sickness. On an average day, 4·54 per cent. of the medical, dental, health visiting, and midwifery staff was absent through long-term illness.

Illnesses of five days or longer were also fairly numerous among the clerical staff at Willowbank House : four individuals were absent from work for periods ranging from 6 to 18 days, losing a total of 58 working days.

From a recent editorial in *The Medical Officer*, it appears that increased sickness was also a feature of other health departments.

Acknowledgments.—I wish to record my appreciation of much kindness and help given to me by the Convener and members of the Health and Welfare Committee, by officials of other Corporation Departments and of other branches of the National Health Service, and by my colleagues in the

Health and Welfare Department. To my colleagues—doctors, dentists, health visitors, midwives, sanitary inspectors, clerks, nursery staffs, &c.—I am under a particular debt of gratitude: I have written this report, but they did the work which it records.

IAN A. G. MACQUEEN,
Medical Officer of Health.

Health and Welfare Department,
Willowbank House,
Willowbank Road,
Aberdeen, 30*th March*, 1953.

CONTENTS.

	Page
SUMMARY OF STATISTICS	ii
PREFACE	iii
1. BACKGROUND DATA: DEMOGRAPHICAL, SOCIOLOGICAL, &C.	1
2. CO-ORDINATION, CO-OPERATION, AND JOINT USE OF STAFF	10
3. VITAL STATISTICS OF 1952	14
4. MATERNITY AND CHILD WELFARE	26
5. DOMICILIARY MIDWIFERY	32
6. HEALTH VISITING	34
7. HOME NURSING	37
8. DOMESTIC HELP	39
9. VACCINATION AND IMMUNISATION	39
10. PREVENTION OF ILLNESS, CARE, AND AFTER-CARE	43
11. CONTROL OF INFECTIOUS DISEASES	51
12. MENTAL HEALTH	59
13. WORK UNDER NURSERIES AND CHILD-MINDERS REGULATION ACT ...	62
14. SCHOOL HEALTH SERVICE	62
15. PORT HEALTH ADMINISTRATION	82
16. FOOD SUPPLY AND FOOD HYGIENE	82
17. SERVICES UNDER NATIONAL ASSISTANCE ACT, &C.	83
18. GENERAL SANITATION	90
19. HEALTH EDUCATION	90
20. LIST OF STAFF	92

CITY OF ABERDEEN.

REPORT BY THE MEDICAL OFFICER OF HEALTH

For the year 1952.

1.—BACKGROUND DATA : DEMOGRAPHICAL, SOCIOLOGICAL, &c.

INTRODUCTION.

A report on the health of a City and on the work of a Health and Welfare Department inevitably consists largely of figures—death-rates and sickness rates, numbers of persons examined, statistics relating to defects found on examination, numbers of visits paid by members of staff, and so forth. Such figures can convey accurate information only if they are studied in the light of the social, economic, industrial, and climatic circumstances of the area to which they relate. A particular infant mortality rate might, for instance, be deemed high and regarded as an indication of unsatisfactory child welfare services in a wealthy, well-housed community, while the same rate in a town with much overcrowding, poverty, and unemployment might be deemed low and regarded as indicating that the services were functioning efficiently.

Some of the obvious points liable to influence the health of the City will already be known to every person who reads this report, *e.g.*, such points as that Aberdeen is a seaport with an extensive fishing fleet, that there is an air-port just outside the City, that Aberdeen is a university town with a flourishing medical school, that the Corporation conduct a training course for health visitors, that the City is the natural commercial and industrial centre for a large agricultural hinterland, and that it has a bracing climate of the east-coast type.

An attempt has, however, been made to set down in this chapter some additional basic demographical and socio-economic data for the City. Some of the figures given below are reproduced from (or based on) Volume 1, Parts 1-4 of the Registrar General's "Report on the Fifteenth Census of Scotland" (H.M. Stationery Office, 1952 and 1953), and printed here by kind permission of the Registrar General. Other figures are given by courtesy of the Ministry of Labour and National Service, while others are taken from data in the possession of the Health and Welfare Department or of other departments of the Corporation. Figures based on the Census Report relate, of course, to 1951, not 1952, but should give a reasonably accurate background against which to study the health and welfare services of the City in 1952.

GENERAL DATA.

Area of City.—In 1951 the area (exclusive of inland water, tidal water, and foreshore) was 10,488 acres. This figure is used in the calculation of density.

In 1952, after the adjustment of boundaries in that year, the area (with the same exclusions) was 11,362 acres.

Population.—The 1951 census enumeration gave a total of 182,729, or when corrected for normal residence, 183,247. The estimated population at the middle of 1952 was 183,626.

The growth of the City (a factor of great importance when housing is considered) may be very roughly summarised thus: for many centuries Aberdeen had a population of under 15,000; during the 18th century it increased to 27,000; in the thirty years, 1801-1831, the population doubled; in the next sixty years it doubled again; and in the last sixty years it has increased by 50 per cent.

Density of Population.—The density varies greatly in different Wards, the over-all average being 17·4 persons per acre. This may be compared with average densities of 14·4 for Edinburgh, 14·5 for Dundee, and 28·2 for Glasgow.

Number of Houses.—The number in 1952 was 52,268, an increase of 583 on the total in the previous year. The distribution of houses in the various Wards was as follows:—

Ward.	No. of Houses.	Ward.	No. of Houses.
No. 1—St. Clements . .	5,025	No. 7—Rosemount . .	3,662
No. 2—St. Nicholas . .	5,587	No. 8—Rubislaw . .	3,667
No. 3—St. Andrews . .	4,651	No. 9—Holburn . . .	4,504
No. 4—St. Machar . .	3,887	No. 10—Ruthrieston . .	4,100
No. 5—Woodside . . .	4,676	No. 11—Ferryhill . .	4,002
No. 6—Cairncry . . .	4,218	No. 12—Torry . . .	4,289
			52,268

Average number of persons per house.—The census figure of 3·48 corresponds closely with 3·29 for Edinburgh, 3·46 for Dundee, and 3·58 for Glasgow.

Rateable Value (1951-52).—£1,973,436.

Population—Age, Sex, and Marital Condition.—The following figures for age, sex, and marital status apply to 1951:—

Age in years.	Males.	Females.	Total.	Percentage of all males.	Percentage of all females.
0- 4 . .	8,461	8,121	16,582	10·1	8·2
5-14 . .	13,025	12,825	25,850	15·6	12·9
15-24 . .	11,926	15,020	26,946	14·2	15·2
25-34 . .	12,087	13,696	25,783	14·4	13·9
35-44 . .	12,511	14,399	26,910	15·0	14·6
45-54 . .	11,185	13,604	24,789	13·4	13·7
55-64 . .	7,434	10,188	17,622	8·9	10·3
65+ . .	7,001	11,231	18,232	8·3	11·3
Not stated . .	6	9	15	—	—
Total . .	83,636	99,093	182,729	100	100
Children under 16 .	22,899	22,156	45,055	—	—

Adults.	Males.	Females.	Total.	Percentage of all male adults.	Percentage of all female adults.
Single . . .	16,385	23,483	39,868	27·0	30·6
Married . . .	40,980	42,692	83,672	67·5	55·7
Widowed or divorced	3,285	10,631	13,916	5·4	13·5
Not stated . .	87	131	218	0·1	0·2

Proportion of Males to Females.—The ratio of males to females is 45·8 : 54·2, or 239 females to every 200 males (whereas, in Scotland as as whole, there are only 219 females to every 200 males). If children under 16 years are excluded, the ratio is higher still—126 women to 100 men.

The Young and the Old.—The percentages of pre-school children, children of school age, and persons over 65 years in the four large cities, are given below:—

	0-4 years.	5-14 years.	65+ years.
Aberdeen . .	9·1 per cent.	14·1 per cent.	10·0 per cent.
Dundee . . .	9·0 ,, ,,	15·2 ,, ,,	10·4 ,, ,,
Edinburgh . .	8·5 ,, ,,	13·3 ,, ,,	11·3 ,, ,,
Glasgow . .	9·1 ,, ,,	15·7 ,, ,,	8·6 ,, ,,

It is interesting to note that the proportion of the population aged 65 years and over has increased in the last twenty years from 7·3 per cent. to 10 per cent.

The following table gives the proportions of the population in various age-groups in 1911, 1921, 1931, and 1951:—

	Under 1 year.	1 and under 5 yrs.	5 and under 15 yrs.	15 and under 25 yrs.	25 and under 45 yrs.	45 and under 65 yrs.	65 yrs. and upwards.
1911 . .	2·23	9·03	22·13	19·13	26·84	15·31	5·33
1921 . .	2·35	6·66	19·41	20·00	27·00	18·42	6·16
1931 . .	1·75	6·81	17·22	18·65	28·51	19·81	7·25
1951 . .	1·63	7·44	14·14	14·76	28·84	23·21	9·98

The estimated population of 183,626 in 1952 includes 2,993 under 1 year, 13,662 aged 1-4, 25,965 aged 5-14, 27,103 aged 15-24, 52,958 aged 25-44, 42,619 aged 45-64, and 18,326 aged 65 and over.

Conjugal Condition.—The outstanding change revealed by a comparison with twenty years ago is that a far higher proportion of men and women aged 20-30 years are married. There is also a slight increase in the proportion of widows (but not of widowers), and a rise in the number of divorced persons (to nearly 1 per 200 population).

Social Class Distribution of Adult Males.—A convenient socio-economic classification is that adopted by the Registrar General who divides adult males according to occupation into five social classes. Class I includes such categories as ship-owners, company directors, architects, journalists, medical practitioners, solicitors, &c.; Class II contains farmers, farm managers, shop keepers, nurses, teachers, police inspectors, &c.; Class III, the biggest group, consists mainly of skilled artists and foremen—market gardeners and market gardening foremen, blacksmiths, shipwrights, plumbers, bus drivers, shorthand typists, postmen, &c.; Class IV is mainly semi-skilled workers—railway ticket collectors, paint sprayers, fishermen, bus conductors, barmen, hospital orderlies, &c.; and Class V includes unskilled workers—agricultural labourers, dock labourers, lift attendants, newspaper sellers, hawkers, &c. Exact figures based on the census enumeration have not been published, but the following percentages, calculated from the gross figures given in the Registrar General's One Per Cent. Sample Tables (H.M. Stationery Office, 1952), give, with a fairly small margin of error, comparative data for the four cities and for Scotland as a whole:—

	Percentage in Each Social Class.				
	I.	II.	III.	IV.	V.
Scotland . .	2·96	13·21	50·92	18·21	14·71
Aberdeen . .	3·65	14·12	48·84	14·12	19·27
Dundee . .	2·03	9·98	51·62	18·45	17·93
Edinburgh . .	5·36	12·71	56·65	10·79	14·50
Glasgow . .	2·07	10·17	54·88	13·60	19·28

It will be noted that Aberdeen is a City with a large proportion of persons in both the lowest and the highest social classes, and with a smaller percentage in Class III than has any other city. In particular, the fact that Aberdeen has a considerably higher proportion in Class V than has any other Scottish city except Glasgow, is of importance in any consideration of the health and welfare services required. It is also interesting to observe that the percentage in Classes IV and V taken together is greater in Aberdeen than in Glasgow. The percentage of persons in Class V is also appreciably higher than in most English cities.

Occupations.—It has not proved possible to provide an exact analysis of the gainfully employed members of the community in respect of occupation.

The Aberdeen Employment Exchange serves Aberdeen City and an adjacent county area (Bucksburn, Dyce, and Cults) with a population of approximately 15,000. According to the Ministry of Labour and National Service, the main occupations in the area served by this Exchange are—

Agriculture and Horticulture.
Fishing.
Stone Quarrying.
Cast Concrete and Monumental Masonry.
Chemicals and Allied Trades.
Engineering, Shipbuilding, and Electrical Goods.
Motor Body Building and Motor Repairing (Garages)
Metal Goods not elsewhere specified.
Woollen and Worsted Manufacture.
Flax Manufacturers.
Net Making and Braiding.
Hosiery and Other Knitted Goods.
Clothing : Tailoring.
  Dressmaking.
  Shirtmaking.
  Boot and Shoe Repairing.
Sawmilling.
Furniture and Upholstery.
Food and Drink: Grain Milling.
  Bread and Biscuit Making.
  Meat Products.
  Milk Products.
  Fish Curing.
  Aerated Water Manufacture.
Wooden Container and Basket Manufacture.
Paper and Printing.
Horn Comb and Plastics Moulding.
Building and Contracting.
Gas, Electricity, and Water Services.
Transport and Communication Services.
Distribution Trades.
Insurance, Banking, and Finance.
Public Administration and Defence.
Professional Services.
Entertainment and Sport.
Catering—Hotels, &c.
Laundry and Dry Cleaning.
Hairdressing.

Unemployment.—Unemployment during most of 1952 was not very extensive although rather more than in previous years. At the latest date for which information is easily available (8th December), the numbers of unemployed persons in the area covered by the Aberdeen Employment Exchange were—

Men.	Boys.	Women.	Girls.
2,477	31	798	29

The male population of Aberdeen includes 55,149 persons aged 15-64 years. A rough estimate of 5,850 males aged 15-64 years in the part of the area outside the City would give a total male population of 61,000, of whom 2,508 were unemployed, a percentage of 4·1.

Housing.

Size of Household and Number of Rooms.—Figures for 1951 are given in the table on page 6. The apparent discrepancy between the total persons and the figure given elsewhere for the population of the City is due to the exclusion of persons in hospitals, old people's homes, lodging-houses, approved schools, prisons, and other residential establishments. The "staircase" inserted in the table gives a rough indication of overcrowding, households to the left and below being, in general, overcrowded. The indication is approximate only, because (*a*) a household may appear in the "overcrowded" section of the table although (owing, for instance, to one of the persons being a young child) there is no legal overcrowding, and (*b*) a household may appear in the "non-overcrowded" section although (owing for example, to sex distribution) there is actually statutory overcrowding.

A comparison of the number of rooms per household in the four large cities is given below:—

	Percentage of Households.			
	Aberdeen.	Dundee.	Edinburgh.	Glasgow.
1 room . .	9·9	10·4	8·0	14·7
2 rooms . .	28·2	40·0	24·1	35·9
3 rooms . .	31·5	28·8	31·9	27·0
4 rooms . .	18·4	12·0	19·6	15·2
5 rooms . .	5·5	4·3	7·9	4·3
6+ rooms . .	6·5	4·4	8·5	2·9

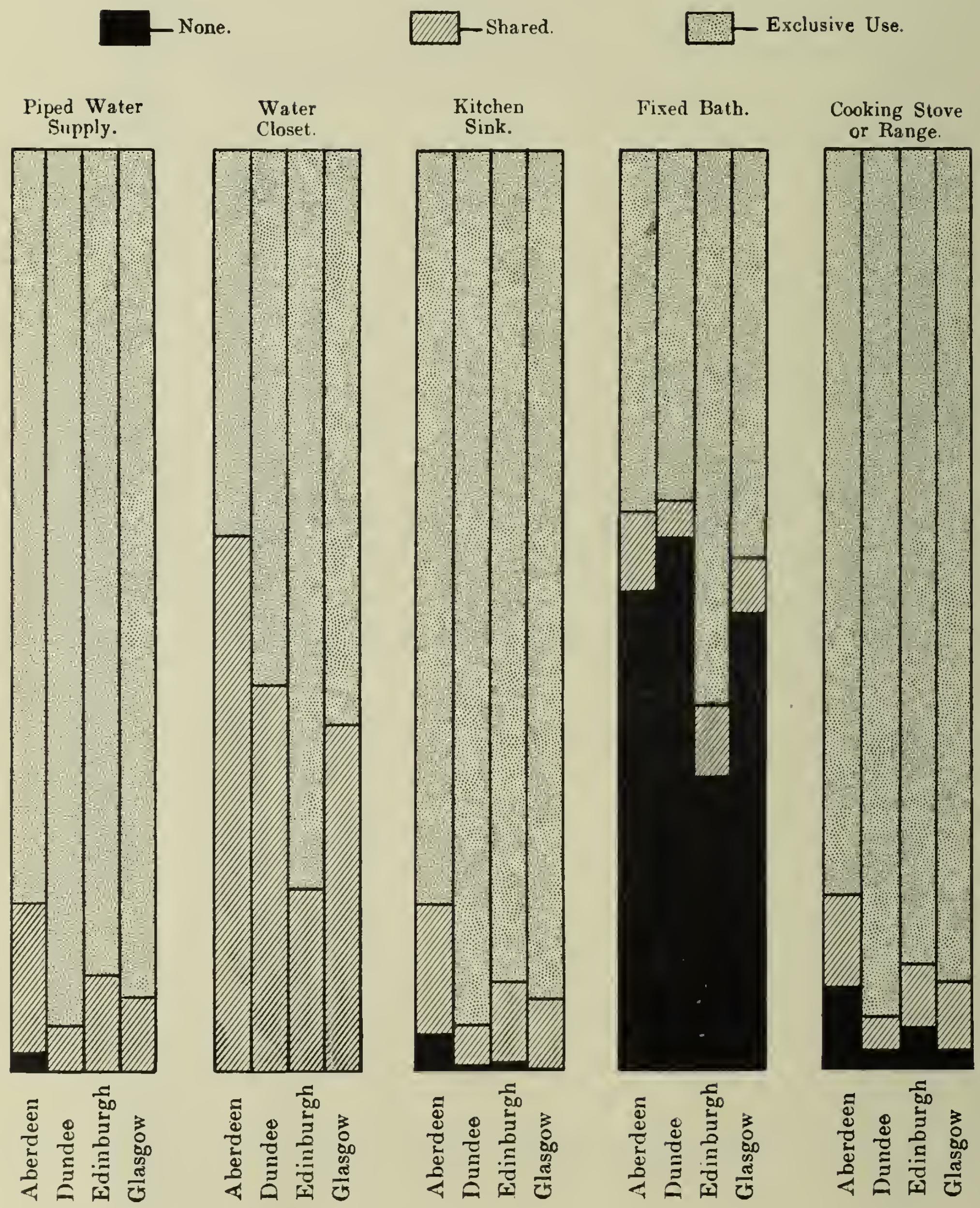
Density—Persons per room.—Probably the best single measure of crowding is obtained by reckoning the proportion of the population living two per room, three per room, and so on. In Aberdeen, 12·6 per cent. of the population (or one person in every eight) live more than two to a room. This figure can be sub-divided into 10 per cent. who are crowded (2-3 per room) and 2·6 per cent. who are very badly crowded (over 3 per room).

Exact national figures have not yet been published, but the figure of 12·6 per cent. may perhaps be compared with the national estimates given in the One Per Cent. Census Sample, namely, 2 per cent. for the entire United Kingdom, and

SIZE OF HOUSEHOLD AND NUMBER OF ROOMS.

NUMBER OF PERSONS IN EACH HOUSEHOLD.	NUMBER OF ROOMS								TOTAL PRIVATE HOUSEHOLDS.	TOTAL PERSONS IN PRIVATE HOUSEHOLDS.
	1	2	3	4	5	6	7	8 and over		
1	1,544	2,303	1,346	708	243	137	73	55	6,409	6,409
2	1,576	4,672	3,716	1,937	830	413	237	248	13,629	27,258
3	1,486	4,343	4,269	1,868	775	377	228	235	13,581	40,743
4	608	2,600	3,928	1,854	542	279	155	220	10,186	40,744
5	84	911	2,166	1,542	272	173	102	171	5,421	27,105
6	16	242	879	983	147	82	50	104	2,503	15,018
7	3	81	382	552	57	25	11	38	1,149	8,043
8	2	27	171	253	30	17	13	22	535	4,280
9	...	9	66	135	30	2	3	7	252	2,268
10	....	3	24	52	16	9	3	4	111	1.110
11	...	...	13	22	13	2	...	6	56	616
12	...	2	3	9	1	...	...	2	17	204
13	...	...	4	6	5	...	...	1	16	208
14	...	...	...	...	2	...	...	...	2	28
15 and over	...	...	...	2	...	...	...	...	2	30
Total Private Households .	5,319	15,193	16.967	9,923	2,963	1,516	875	1,113	53,869	..
Total Persons in Private Households .	12,139	42,001	58,508	39,291	9.955	5,008	2,899	4,263	...	174,064

Percentage of Households with sole Use, Share, or no use of Facilities.



9·4 per cent. for Scotland. The Scottish average is, of course, distorted by the tremendous crowding in Glasgow (where 24·6 per cent. of the people live more than two to a room). The exact figures for other Scottish cities are 11·5 per cent. in Edinburgh, and 14·3 per cent. in Dundee.

In any consideration of the health needs of Aberdeen, it is important to remember the factor of crowding. The figure of 12·6 per cent. living more than two per room contrasts sharply with the provisional figures for comparable English cities, *e.g.*, Brighton (1·4 per cent.), Plymouth (1·1 per cent.), Coventry (1·8 per cent.), Salford (4 per cent.), and Sunderland (8 per cent).

Household Arrangements.—The census enquiry regarding piped water supply, cooking facilities, kitchen sink, water closet, and fixed bath has revealed that, in 1951, Aberdeen was, in all but one of these respects, the most poorly equipped of the Scottish cities. Only 38·8 per cent. of households in Aberdeen had the exclusive use of all five facilities, as compared with 37·9 per cent. in Dundee, 59·7 per cent. in Edinburgh, and 43·9 per cent. in Glasgow. At the other end of the scale, 4,004 households, the majority of which were households of more than two persons, shared all five conveniences, a percentage of 7·4 per cent., contrasting with 2·7 per cent. in Dundee, 5·3 per cent. in Edinburgh, and 4·8 in Glasgow; and 67 Aberdeen households possessed none of the five facilities, whereas in Glasgow, Edinburgh, and Dundee there were only 43, 39, and 55 households, respectively, with none of these facilities.

One is so apt to think of Glasgow (in view of its overcrowding) as being environmentally the worst of the British cities, that it comes as a profound shock to realise that Aberdeen is less favourably placed than Glasgow in respect of each of the five points selected for investigation by the Registrar General.

The following tables and appended diagram give comparative figures for the four cities:—

PERCENTAGE OF HOUSEHOLDS IN DIFFERENT CITIES WITH EXCLUSIVE USE, SHARE, OR NO USE OF CERTAIN FACILITIES.

Piped Water Supply.	Aberdeen	Exclusive	81·4
		Shared	16·5
		None	2·1
	Dundee	Exclusive	94·6
		Shared	4·8
		None	0·6
	Edinburgh	Exclusive	89·5
		Shared	10·2
		None	0·3
	Glasgow	Exclusive	92·0
		Shared	7·9
		None	0·1

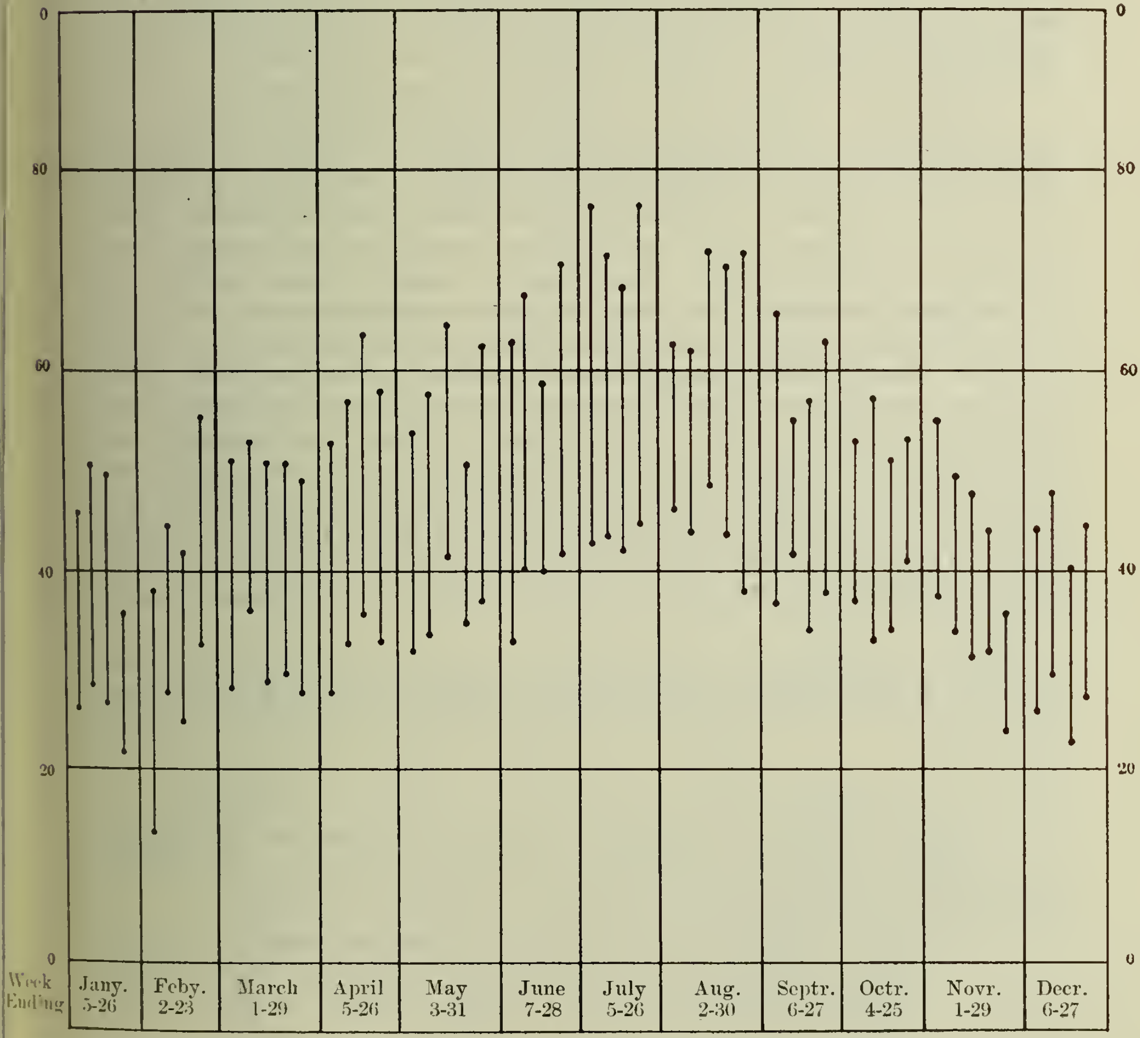
Percentage of Households in Different Cities with Exclusive Use, Share, or no use of Certain Facilities.—(Continued).

Water Closet.	Aberdeen	Exclusive	42·3
		Shared	57·2
		None	0·5
	Dundee	Exclusive	57·2
		Shared	42·4
		None	0·4
	Edinburgh	Exclusive	80·3
		Shared	19·5
		None	0·2
	Glasgow	Exclusive	62·4
		Shared	37·5
		None	0·1
Kitchen Sink.	Aberdeen	Exclusive	82·0
		Shared	13·7
		None	4·3
	Dundee	Exclusive	94·8
		Shared	4·5
		None	0·7
	Edinburgh	Exclusive	90·3
		Shared	8·9
		None	0·8
	Glasgow	Exclusive	92·2
		Shared	7·5
		None	0·3
Fixed Bath.	Aberdeen	Exclusive	39·2
		Shared	9·4
		None	51·4
	Dundee	Exclusive	38·0
		Shared	3·7
		None	58·3
	Edinburgh	Exclusive	60·4
		Shared	7·4
		None	32·2
	Glasgow	Exclusive	44·1
		Shared	5·8
		None	50·1
Cooking Stove or Range.	Aberdeen	Exclusive	81·1
		Shared	9·8
		None	9·1
	Dundee	Exclusive	93·6
		Shared	4·0
		None	2·4
	Edinburgh	Exclusive	88·3
		Shared	7·0
		None	4·7
	Glasgow	Exclusive	90·5
		Shared	6·9
		None	2·6

Climate.—The lowest temperature registered during the year was 13°F (at the end of January), and the highest was 77°F (at the beginning of July and again towards the end of that month). The following diagram gives the maximum and minimum temperatures during each week of the year. The total rainfall during the year (at Craibstone, just outside the City) was 33·01 inches:—

CITY OF ABERDEEN.

TEMPERATURE OF ATMOSPHERE—WEEKLY MAXIMA AND MINIMA.
°FAHR.
YEAR, 1952.



2.—CO-ORDINATION, CO-OPERATION, AND JOINT USE OF STAFF.

Co-ordination of Health Services.

Although the National Health Service has been divided into three parts, it could not function unless there was close co-ordination of the component units, with each portion ready to co-operate with the others. In this area, co-ordination and co-operation is a very real thing: not only do the officials of Hospital Board, Local Authority, and Executive Council work in harmony but this co-operation, in at least some cases, extends to the various individuals actually confronting a patient. In Aberdeen there has been set up a Joint Co-ordinating Committee for the Health Services comprising representatives of the Local Health Authority, the Regional Hospital Board, and the Executive Council. This Committee meets, on an average, once every two months, when matters of common interest are raised; and this facilitates discussion of problems affecting the various services.

Co-ordination is appreciably improved by the fact that the Chairman of the Regional Hospital Board happens also to be Convener of the Health and Welfare Committee of the City. Again, the Medical Officer of Health and the Depute Medical Officer of Health are lecturers in Public Health and Child Welfare, respectively, in the University and are therefore brought into contact with other members of the University staff. This arrangement enables a young doctor to turn to the Health Department for advice on medico-social problems in exactly the same way as he can turn to his former clinical teachers for advice on clinical problems, because in both cases the teacher-student relationship already exists. Yet again, the Assistant Medical Officers for Maternity and Child Welfare hold honorary appointments with the Sick Children's Hospital, and registrars there take certain child welfare clinics for the local authority. Another useful point is that the consultant staff of the Maternity Hospital conduct ante-natal and post-natal clinics in close association with doctors from the Health and Welfare Department. Also several clinicians give lectures to health visitor students, thus bringing these experts in curative medicine into close contact with the preventive medical service.

The Medical Officer of Health serves on the Board of Management for the Aberdeen Special Hospitals and is at present a member of the Local Medical Committee and of the Council of the Aberdeen Branch of the British Medical Association.

Co-operation of local authority staff in treatment of patients in hospitals.

(*a*) Before a patient is admitted to hospital.—Three examples will illustrate the co-operation which takes place between the staff of the local authority and the hospital authority when a patient is about to be admitted to hospital:—

(1) In each notified case of tuberculosis, a sanitary inspector submits a report on the housing conditions of the patient prior to his admission to hospital. This report is also made in respect of other ailments when desired by the hospital authorities.

(2) A health visitor also submits, on request, reports on the home and domestic conditions.

(3) The local authority provide, while the patient is awaiting admission to hospital, such assistance as home helps, district nurses, or night nurses.

(*b*) While a patient is in hospital:—

(1) If the patient has no relative or friend willing and able to look after his house, the local authority assume that responsibility. The number of cases where the local authority acted in this capacity during the year is mentioned in the Section dealing with National Assistance.

(2) Accommodation in residential and day nurseries is available where the patient has children under five years of age who cannot otherwise be cared for. In other cases, the difficulty may be surmounted by the provision of home helps.

(3) In all cases of infectious disease, a health visitor calls and advises the occupants of the house about disinfection and the precautions to be taken to prevent the spread of the disease.

(*c*) When a patient is ready for discharge:—

(1) In certain instances, a close liaison is maintained between the hospital almoners and the domestic help service, so that, when a patient is discharged from hospital and is not fit to resume normal duties in the home, the services of a home help are made available.

(2) Health visitors are also available under the Care and After-Care services of the local authority.

(3) When pre-school or school children are discharged from hospital, the local authority is sometimes informed of the fact and of the child's condition and needs, thus ensuring that the authority have all relevant facts to enable them to discharge their statutory duties. Unfortunately, this information is as yet supplied only in respect of tuberculosis, fevers, and accidents. There would perhaps be no point in seeking immediate extension of information, as, owing to shortage of staff, the local authority could not as yet make adequate use of the information if it were supplied.

Co-operation of local authority staff in treatment of patients at home.

With regard to the treatment of patients in their own homes, there is some liaison between the general practitioners and the local authority, so that the day and night nursing services are made available in all necessary cases, as are home helps. In addition, the authority's health visitors are available for the after-care services. As mentioned elsewhere, the health visiting service of prevention and after-care needs greater development, and it is also important that general practitioners should be made more fully aware of the benefits that this service can confer on patients.

The Corporation's schemes for the handicapped, crippled, deaf and dumb, and partially sighted were being drafted at the end of the year, and these will also ensure that such persons are given all necessary assistance.

It might be mentioned that the Corporation approved in principle at the end of the year of the erection of a clinic which would also contain accommodation for several general practitioners. The mere fact of the health department staff and general practitioners operating from the same building may do much to ensure close liaison and better appreciation by each section of the value of the work carried out by the other.

As stated elsewhere in this report, the dividing line between health and welfare is not easily marked, and the fact that the department is a Health and Welfare Department ensures that the services are provided without the necessity of prior determination whether a particular case falls under "after-care" or under "welfare" and without the possibility of a patient being passed from one department to the other without assistance being given by either.

Assessment of effectiveness of these arrangements.

The co-ordination with hospital and consultant services is, on the whole, extremely good, but there are "pockets" where only lip-service is paid to co-ordination.

The co-ordination with the general practitioners' service varies from excellent to negligible, with the majority falling into an intermediate category. As time passes, the general practitioner service and the local authority service are probably tending to regard each other more and more as complementary and not as wholly separate services.

Suggestions for improvement of co-ordination.

Being expressly directed by the Department of Health for Scotland to insert in this report any suggestions I may have for improvement of co-ordination, I set down some ideas under three headings:—

(A) *Suggestions involving national action.*

(*a*) Co-ordination and co-operation is hampered in certain instances because the local authority cannot play their important part owing to staff shortages. These shortages are not the fault of the local authority but reflect national shortages, and can be remedied only by national action. This point is already discussed in the preface to the report.

(*b*) The disparity in salaries of different types of doctors may lead to unconscious snobbery. A general practitioner may find it easier to accept advice from a consultant who is usually paid rather more than the general practitioner than to accept medico-social advice from an assistant medical officer of health earning perhaps half the net income of the general practitioner; and an assistant medical officer of health may have fewer opportunities of social contacts with other doctors than would be possible if the problem of remuneration were tackled at a national level.

(B) *Suggestions involving University action.*

Although the amount of time devoted in the medical curriculum to public health and social medicine has increased in recent years, it is still inadequate: the young doctor starting out in general practice is usually far more aware of clinical problems than of medico-social problems. Much more emphasis on public health and social medicine is necessary in the undergraduate curriculum. In this connection, it may be worthwhile to mention that, in Aberdeen, under recently started arrangements, medical undergraduates will now visit, under the supervision of health visitors, a few families in their own homes. This is at least a step in the right direction.

(C) *Suggestions involving local action.*

(*a*) Some of the older clinicians sometimes seem to think of the local health authority as concerned mainly with control of infectious disease and with sanitary defects. It is desirable that all suitable opportunities be used to publicise the duties of the local health authority in respect of promotion of health, prevention of disease (not merely of infectious disease), care and after-care.

(*b*) At present, hospitals undertake considerable research in treatment of advanced disease, but there is relatively little research into the causes, recognition, and prevention of early disease. It may be that there is a field here in which, to the benefit of the community, there could co-operate general practitioners (who, individually, may see too few cases of a disease for satisfactory research work and who, individually, lack the statistical machinery available in a large department) and local health authority staff. Such co-operation would also help to improve general relations.

(*c*) The decision of the Corporation to erect at Northfield a clinic where general practitioners will also consult has interesting potentialities, and opportunity should be taken to develop such centres in other housing areas.

Steps taken to inform general practitioners and public about services.

In April, 1951, a memorandum was prepared and issued to general practitioners detailing the various services then available to the elderly. This memorandum included not only the services provided by the local authority but also those provided by voluntary organisations in the City. It has not, however, been subsequently brought up to date, and it included only the services for one section of the community.

At the various clinics and centres, leaflets prepared by the Scottish Council for Health Education are distributed; but it is suggested that consideration might be given to the publication of a short summary of the health and welfare services made available to the general public by the local authority.

Joint use of Staff.

(*a*) Owing to the grave shortage of dental officers, an approach was made to the Local Dental Committee to enquire whether the dental officers in Aberdeen would be prepared to undertake some work in the Corporation's clinics, but a reply was received to the effect that the dental officers gave a certain measure of priority to children and expectant mothers and accordingly did not feel that they could undertake work on a sessional basis.

(*b*) As most general practitioners have not received post-graduate training in public health and social medicine and are also, as a rule, very busy, the question of the utilisation of their services in clinics has not been raised. It may be, however, that, when the above-mentioned clinic is provided in the Northfield area and general practitioners are actually consulting in the building, the question of offering clinic sessions to selected practitioners may merit consideration.

(*c*) Joint use of staff is at present practised most in respect of hospital and local authority services:—

(1) The chest physician of the Regional Board undertakes for the local authority much of the preventive work arising in respect of tuberculosis, and the five health visitors at present allocated to tuberculosis work co-operate with the hospital staff.

(2) As stated earlier, the gynæcological staff of the Maternity Hospital are employed in the local authority's ante-natal clinics.

(3) Pædiatricians and the medical staff of the local authority co-operate as already indicated.

(4) Occasional use is made of the psychiatric social worker.

(5) The staff of the City Hospital assist the local health authority staff in certain port health duties.

Joint use of premises.

There is no joint use of premises by the general practitioners, but, as mentioned earlier, this may come when the Northfield Clinic is built.

The Orthopædic Clinic is held at Woolmanhill, and the consultants and medical staff of the local authority co-operate. Similarly, at the Regional Clinic for the Blind, the consultants of the Regional Hospital Board conduct the clinic with a health visitor in attendance.

3.—VITAL STATISTICS OF 1952.

An attempt has been made to record in the next few pages most of the information on which the healthiness or otherwise of a city is normally judged.

The table opposite gives the number of births, still-births, and infant deaths in the year and in a number of previous years.

BIRTHS, STILL-BIRTHS, INFANT MORTALITY.

YEARS 1942-1952.

YEAR.	No. of Live Births.	Live Births per 1,000 of Population.	Illegitimate Births, per cent. of Live Births.	No. of Still Births.	Still Births per 1,000 Total Births, incl. Still Births.	No. of Deaths of Infants under 1 Year.	No. of Deaths of Infants under 1 Month.	Neo-natal Deaths per cent. of Total Infant Deaths.	Death-rates from all Causes per 1,000 Live Births. Rates.				Death-rates among Infants under 1 Year of Age from Various Causes per 1,000 Live Births.									
									Total under one Year.	UnderOneMonth (Neo-natal Rate).	One Month and under SixMonths.	Six Months and under One Year.	Tuberculosis.	Common Zymotic Diseases.	Pneumonia and Bronchitis.	Diarrhœa and Enteritis.	Congenital Malformations.	Injury at Birth.	Atelectasis.	Immaturity.	Accidents.	Other causes.
1952 .	**3025**	**16·5**	**5·7**	**57**	**18**	**90**	**54**	**60**	**30**	**18**	**8**	**4**	**0**	**0**	**6**	**0**	**5**	**1**	**8**	**2**	**1**	**7**
1951 .	3028	16·5	5·4	66	21	82	55	67	27	18	6	3	0	1	6	0·3	4	2	5	6	2	1
1950 .	3226	17·2	5·3	74	22	92	54	54	29	17	10	2	0	0·3	6	0·3	5	2	4	5	2	5
1949 .	3306	17·5	5·7	63	19	100	54	54	30	16	12	2	0·3	1	7	3	5	1	5	4	1	3
1948 .	3598	19·1	5·9	98	27	121	72	60	34	20	10	4	0	1	5	5	4	4	5	6	2	2
1947 .	4124	22·0	5·9	107	25	263	108	41	64	26	28	10	0.2	2	13	22	4	2	8	5	2	6
1946 .	3762	20·4	7·0	115	30	158	92	58	42	24	16	2	0·5	0·3	6	9	5	3	7	7	1	3
1945 .	2830	15·5	10·0	71	24	152	76	50	54	27	21	6	0·4	2	8	11	5	6	4	11	0·4	6
1944 .	2989	16·5	9·2	68	22	169	83	49	57	28	23	6	0·3	1	14	7	7	5	6	8	2	7
1943 .	2876	16·0	8·9	96	32	195	111	57	68	39	24	5	0	2	11	11	5	7	9	11	1	11
1942 .	2904	16·1	8·5	91	30	194	104	54	67	36	22	9	1	3	10	11	6	3	4	21	0	8

LIVE BIRTHS.

The total number of live births during 1952, corrected for "transfers," was 3,025, of whom 2,853 were legitimate and 172 illegitimate. The live birth rate was 16·5 per 1,000 of population, the same rate as in 1951 but lower than in most other recent years.

The following table shows the rates for Aberdeen and for all Scotland over a period of seven years. The trend in Aberdeen is very similar to that in the country as a whole.

	Live Birth Rate per 1,000 Population.	
Year.	Aberdeen.	Scotland.
1952	16·5	17·7
1951	16·5	17·7
1950	17·2	17·9
1949	17·5	18·5
1948	19·1	19·4
1947	22·0	22·0
1946	20·4	20·3

In 1952, the birth rates in the other principal cities were:—Glasgow, 18·7; Edinburgh, 15·0; and Dundee, 17·7.

The **natural increase** for the year (*i.e.*, the excess of births over deaths) was 877, as compared with 847 in 1951 and 960 in 1950.

Sex-ratio of births.—Of the total 3,025 live births, 1,576 were males and 1,449 were females, giving a ratio of 1·09 (*i.e.*, 109 males per 100 females). The sex-ratio in Aberdeen has been consistently high in recent years; it was 1·11 in 1951 and 1·07 in 1950.

Illegitimate Live-Births.—In 1952, there were 172 illegitimate births, representing a rate of 5·7 per cent. of the total live births. For all Scotland, the rate was 4·8 per cent. The 1952 rate is the highest in Aberdeen since 1949, and the high illegitimate birth rate—which in one year actually amounted to 10 per cent. of all live births—is a grave and continuing social problem.

STILL-BIRTHS.

There were 57 still-births in 1952, as compared with 66 in the previous year. One of the most gratifying features of the year is the still-birth rate which, after attaining a remarkably low level in 1951, fell to a new low record. For this very fine achievement credit is due to all concerned with ante-natal and obstetrical care—hospital staff, local authority doctors and nurses, and general practitioners. Particularly important is the co-operation at ante-natal clinics of clinical experts from the staff of the Hospital Board and medico-social experts from the staff of the Corporation. Nearly 90 per cent. of expectant mothers attend these clinics.

The still-birth rate for 1952 was 18 per 1,000 live and still births. Corresponding data for Scotland and for the other principal cities are as follows:—

	Still-birth Rate per 1,000 Total Births 1952.		Still-birth Rate per 1,000 Total Births 1951.
All Scotland	26	...	27
Glasgow	27	...	28
Edinburgh	27	...	27
Dundee	24	...	25
Aberdeen	**18**	...	**21**

Thus, Aberdeen continues to have the lowest still-birth rate.

Of the 57 still-births occurring in the City (33 males and 24 females), 48 occurred in institutions and 9 at home, the latter figure including 5 cases in which the expectant mother had made an arrangement for the confinement to take place at the Maternity Hospital.

On investigation, it was ascertained that 21 (or 37 per cent.) were primapara pregnancies; 16 (or 28 per cent.) were second pregnancies, and the remaining 20 (or 35 per cent.) were subsequent pregnancies. The following summary shows the ages of the mothers:—

	TOTAL	AGE OF MOTHER					
		Under 20 years	20-24	25-29	30-34	35-39	40+
1st Pregnancy	**21**	1	10	6	2	1	1
2nd Pregnancy	**16**	—	4	4	4	2	2
Subsequent Pregnancies	**20**	—	2	2	8	8	—
TOTAL	**57**	**1**	**16**	**12**	**14**	**11**	**3**

Inquiry was also made about the causes of the still-births, and these are summarised below in accordance with the International Statistical Classification of Causes of Still-birth:—

Diseases and conditions of pregnancy and childbirth—		
Accidental hæmorrhage	10	
Pre-eclamptic toxæmia	5	
	—	15
Difficulties in labour		2
Birth Trauma		2
Congenital malformation of fœtus		18
Placental and cord conditions—		
Prolapsed cord	4	
Placenta infarction	2	
	—	6
Diseases of fœtus and ill-defined causes—		
Prematurity—cause unknown	5	
Full-term—cause unknown	9	
	—	14
		—
		57
		=

INFANT DEATHS.

In 1952, there were 90 deaths of babies under one year of age, as compared with 82 in 1951 and 92 in 1950. The infant mortality rate, expressed as the number of deaths of babies during the year per 1,000 live births, was 30, compared with 27 in 1951 and 29 in 1950.

Comparison with National Figures and with other Cities.—The average rates for all England and Wales and all Scotland, as well as for the four principal cities, are given below for the last three years—

	Infant Death Rates.		
	1952.	1951.	1950.
England and Wales . . .	28	30	30
Scotland	35	37	39
Glasgow	41	46	44
Edinburgh	29	27	29
Dundee	31	41	50
Aberdeen	**30**	**27**	**29**

Unfortunately, therefore, Aberdeen is no longer better than the average for England and Wales, and no longer shares with Edinburgh first place among the four main Scottish cities. The accompanying chart shows the infant mortality rate in Scottish cities and in Scotland as a whole since 1856.

Causes of Infant Deaths.—Table I, at the end of this section of the Report, gives details of the causes of death and the ages at which each child died. An analysis of the infant deaths that have occurred during the last three years reveals that the death-rates from various causes were as follows:—

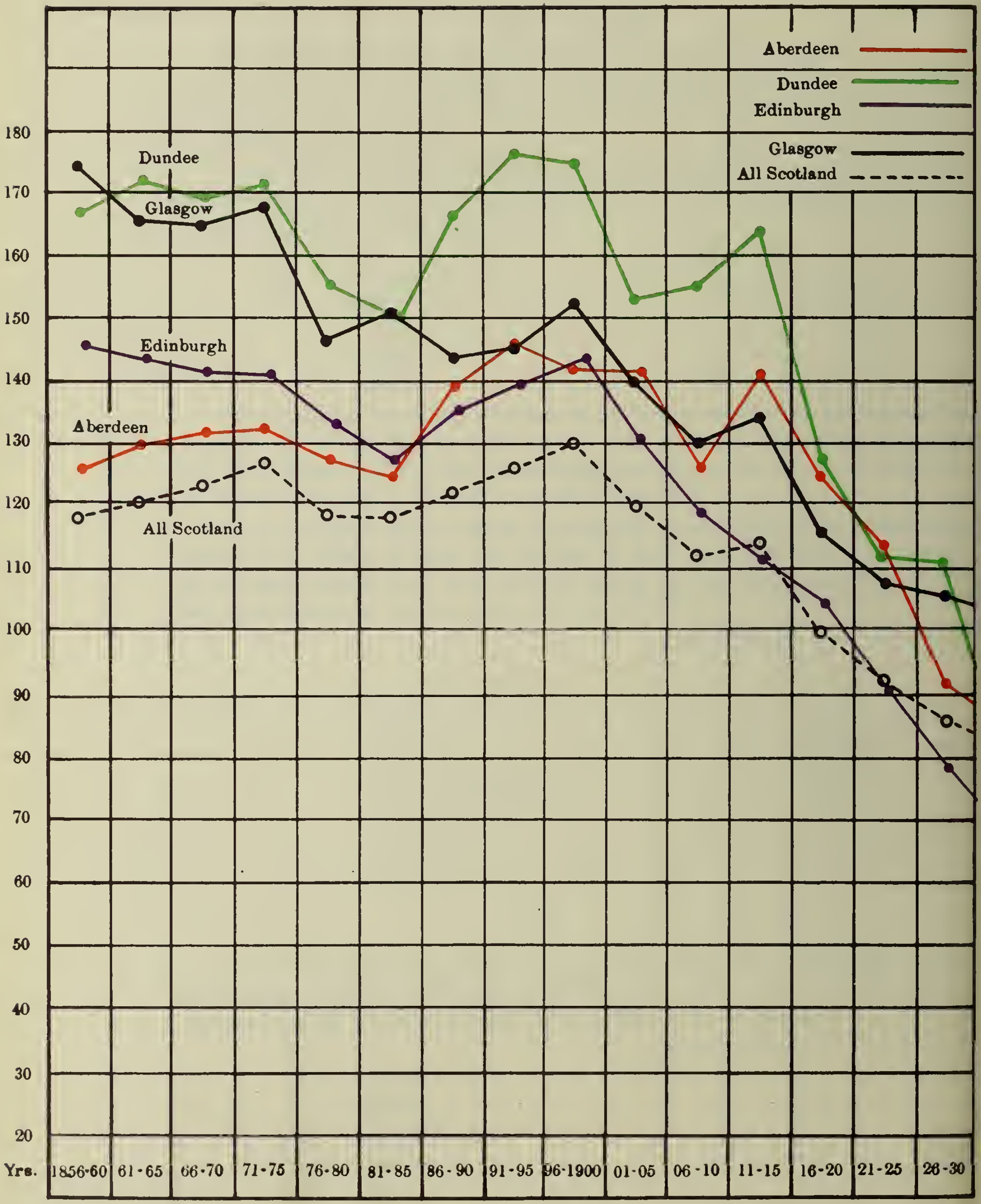
	Infant Death Rates per 1,000 live births.		
	1952.	1951.	1950.
Congenital malformations . .	5	4	5
Immaturity	2·3	6	5
Atelectasis	8	5	4
Birth injuries	1·3	2	2
Diarrhœa and enteritis . .	0	0·3	0·3
Pneumonia and bronchitis . .	6	6	6
Common infections . . .	0	1	0·3
Tuberculosis	0	0	0
Overlaying and other accidents .	1	2	2
Other causes	6·2	1	4
Total . .	30	27	29

Neo-natal Deaths.—In 1952, the number of deaths of infants under the age of one month was 54, as compared with 55 in 1951. The neo-natal death-rates for Scotland and for the four principal cities in 1950-52 are as follows:—

	Neo-natal Death Rates.		
	1952.	1951.	1950.
Scotland	22	22	23
Glasgow	24	25	25
Edinburgh	17	17	18
Dundee	20	25	29
Aberdeen	**18**	**18**	**17**

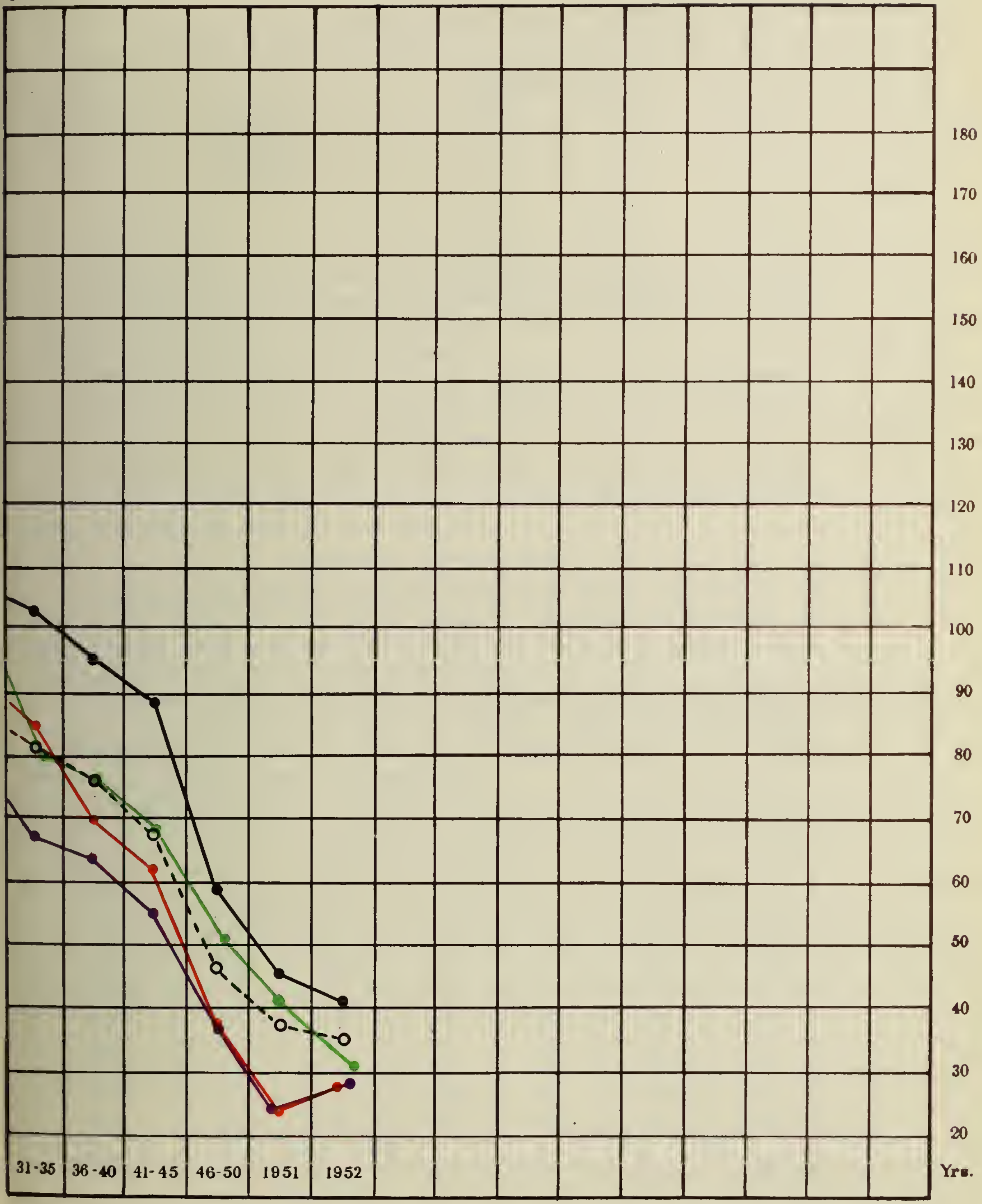
INFANT MORTALITY RATE, 1856-1952—

Deaths under 1 year



-QUINQUENNIAL AVERAGES. 1856-1950.

per 1,000 Births.



MORTALITY IN PRE-SCHOOL PERIOD (1-5 years).

During 1952, 13 children aged 1-5 years died. Details are—

Age-group.	Number of Deaths in 1952.	1951.
1-2 years	6	4
2-3 years	3	4
3-4 years	2	3
4-5 years	2	5
	13	16

Of the 13 deaths in 1952, one was due to accident—a motor vehicle accident. In the previous year, there were two fatal accidents at this age-period (one a burning accident and the other a motor vehicle accident), and in 1950 there were nine (including six due to motor vehicle accidents).

There was one death from respiratory tuberculosis, one from tuberculous meningitis, one from meningococcal septicæmia, and none from other infections.

MARRIAGES.

During 1952, there were 1,929 marriages within the City. This is equivalent to a rate of 10·5 per thousand of population. The rates in previous years were:—1951, 10·0; 1950, 9·9; 1949, 9·7; and 1948, 11·1.

MATERNAL MORTALITY.

According to the Registrar-General's Preliminary Return for 1952, in all Scotland, 92 women died from causes peculiar to pregnancy and childbirth (as compared with 99 in 1951 and 106 in 1950); and deaths from puerperal sepsis numbered 22 (as against 27 in 1951 and 23 in 1950).

In Aberdeen, during 1952, there were two deaths from causes related to pregnancy and childbirth, and in neither case was the death due to puerperal sepsis. In 1951, there were four deaths, including one from puerperal sepsis; and, in 1950, there was one death, not due to puerperal sepsis.

The following table gives a comparison between Aberdeen and all Scotland in recent years:—

Rates per 1,000 live and still births

Year	Maternal Mortality		Puerperal Sepsis		Other Puerperal Conditions	
	Scotland	Aberdeen	Scotland	Aberdeen	Scotland	Aberdeen
1952	**1·0**	**0·6**	**0·2**	**0·0**	**0·8**	**0·6**
1951	1·1	1·3	0·3	0·3	0·8	1·0
1950	1·1	0·3	0·2	0·0	0·9	0·3
1949	1·3	0·9	0·24	0·3	1·01	0·6
1948	1·5	1·1	0·29	0·0	1·25	1·1
1947	2·0	1·2	0·3	0·24	1·7	0·95
Average **1947-1951**	**1·4**	**1·0**	**0·3**	**0·2**	**1·1**	**0·8**

DEATHS.

The total number of deaths, the death-rate per 1,000 of population, and the average age at death for each of the years 1947-1952, are given in the following table:—

Year.	Number.	Rate per 1,000 of Population.	Average age at Death.
1952	2,148	11·7	64·6
1951	2,181	11·9	65·7
1950	2,266	12·1	64·9
1949	2,213	11·7	64·1
1948	2,098	11·1	61·7
1947	2,242	11·9	57·3
Mean of 1947-51	2,200	11·7	62·7

There were 2,148 deaths in 1952, as compared with 2,181 in 1951. The death-rate was 11·7 in 1952 as compared with 11·9 in 1951. For all Scotland, the death-rate in 1952 was 12·0 and, in 1951, 12·9.

The average age at death of all persons dying during 1952 was 64·6 years, as compared with 65·7 in 1951, which was the highest average age at death yet recorded in Aberdeen. It is interesting to note that, in the quinquennium 1891-95, the average age at death was 32·9 years.

Age at Death.—Of the 2,148 deaths, 267 (or 12·4 per cent.) occurred in persons below the age of 45 years. In this young age-group, 59 deaths were due to malformations and diseases of early infancy; 48 to malignant disease; 41 to violence; 25 to diseases of the circulatory system; 19 to pneumonia and bronchitis; 13 to tuberculosis; and 8 to infectious diseases.

514 (or 23·9 per cent.) occurred in the age-period 45-64 years, so that a total of 781 fatalities (or 36·3 per cent.) occurred before the age of 65 years.

576 deaths (or 26·8 per cent.) occurred in the age-period 65·74 years, and 791 (or 36·8 per cent.) occurred at ages of 75 and over.

Causes of Death.—Table II at the end of this section gives full details of the causes of death operating in each age-group; and the diagram below shows some of the more important causes. It is interesting to note that 73 per cent. of all deaths fall under three headings—diseases of circulatory system, diseases of nervous system, and malignant diseases.

PROPORTION OF DEATHS FROM VARIOUS CAUSES TO TOTAL DEATHS—1952.

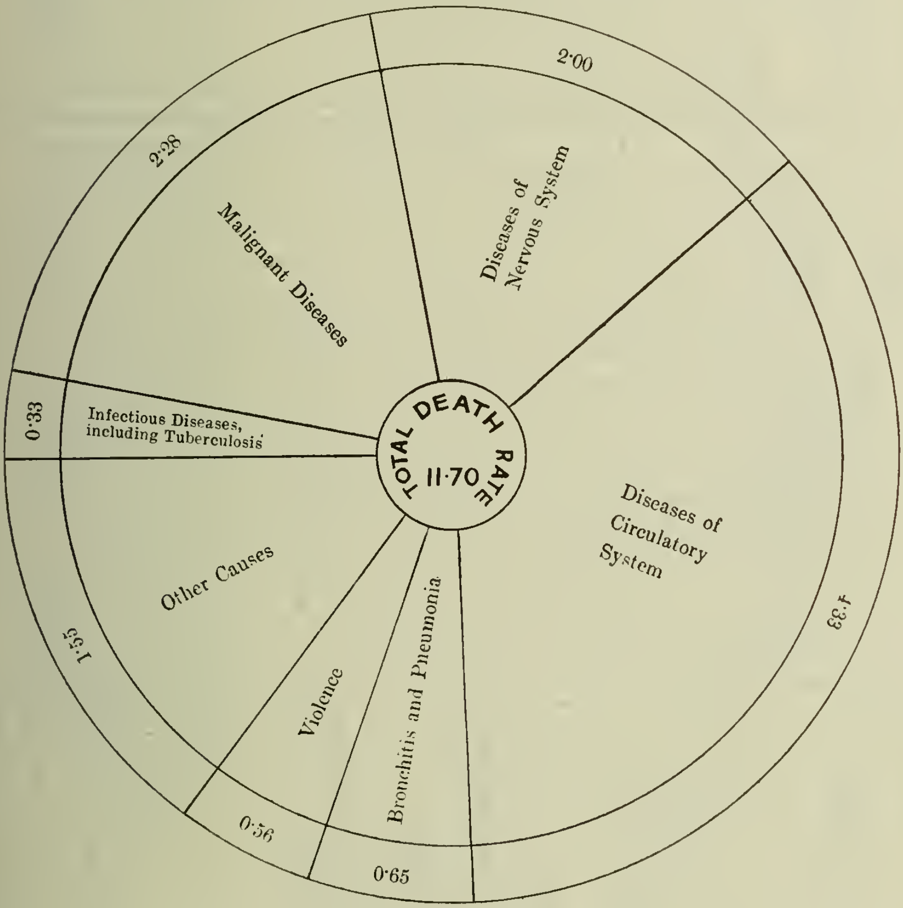


Table III gives for a number of successive years the death-rates at all ages from selected causes, and Table IV gives in summary form details of population, marriages, births, deaths, average age at death, and infant deaths for a number of years and for quinquennial averages.

TABLE I.—CAUSES OF DEATH AMONG CHILDREN UNDER FIVE YEARS OF AGE.

YEAR 1952.

CAUSES OF DEATH	AGE																	Average for preceding 5 years (1947-51).	
	FIRST YEAR												SECOND TO FIFTH YEARS						
	First Four Weeks				First Three Months			The Four Quarters											
	0—1	—2	—3	—4	*0—1	—2	—3	*0—3	—6	—9	—12	Total	—2	—3	—4	—5	Total	0—1	1—5
Tuberculosis { Respiratory	...	...	...	...	...	...	...	...	...	...	...	...	1	..	...	...	1	0·4	0·4
Tuberculosis { Other Forms	...	...	...	..	...	...	...	...	...	...	...	...	--	...	...	1	1	...	1
Cerebro spinal Fever	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	0·2	...
Diphtheria	..	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	0·2
Dysentery	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	0·2	...
Measles	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	1	0·2
Poliomyelitis, Acute	...	...	...	...	..	...	...	...	...	...	...	...	...	...	...	...	...	...	1
Scarlet Fever	..	...	...	...	..	...	...	...	...	...	...	...	...	...	...	...	...	...	0 2
Whooping Cough	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	2	0·2
Other Infective and Parasitic Diseases	...	...	...	...	...	...	...	...	1	...	...	1	2	...	...	...	2	1	2
Pneumonia	...	...	...	...	...	5	1	6	5	...	...	11	...	1	...	...	1	19	2
Bronchitis	...	...	...	...	...	1	..	1	..	...	...	1	...	...	1	...	1	2	0 6
Diarrhœa and Enteritis	...	...	...	...	...	...	...	...	...	...	...	...	1	...	...	...	1	23	0·6
Other Digestive Diseases	...	...	...	...	...	...	...	...	1	...	...	1	...	1	...	...	1	1	0·6
Congenital Malformations	5	2	...	...	7	2	..	9	..	3	2	14	...	...	...	...	...	15	1
Injury at Birth	3	...	...	...	3	...	...	3	...	...	...	3	...	...	...	...	...	9	...
Post-natal Asphyxia and Atelectasis	19	3	1	...	23	...	...	23	...	...	...	23	...	..	...	...	...	19	...
Pneumonia of Newborn	3	1	2	. .	6	...	...	6	...	...	...	6	...	...	...	...	...	5	...
Other Diseases peculiar to Early Infancy	6	...	...	..	6	...	...	6	...	...	...	6	...	...	...	...	...	5	...
Immaturity	7	...	...	...	7	...	...	7	...	...	...	7	...	...	...	...	...	18	...
Suffocation	...	...	...	...	...	1	1	2	1	...	...	3	...	...	...	...	...	5	0·2
Other Accidents	...	...	...	...	...	...	...	...	...	1	...	1	1	...	..	...	1	...	5
Other Causes	2	...	...	..	2	2	1	5	2	3	3	13	1	1	1	1	4	6	3
ALL CAUSES	45	6	3	...	54	11	3	68	10	7	5	90	6	3	2	2	13	132	18
Average for preceding 5 years, 1947-1951	55	5	2	4	69	12	11	92	24	11	5	132	8	4	3	3	18	...	...

* This column includes all deaths in preceding columns.

Table II.—Aberdeen.—Mortality at Various Age Periods from Various Causes.

(Corrected for transferred deaths.)

Age.	All Causes.	Infectious and Parasitic Diseases (excl. Tuberculosis).		Tuberculous Diseases.		Malignant Diseases.	Dis. of NervousSyst. and Sense Organs.		Dis. of Circulatory System.	Respiratory Diseases.			Dis. of Digest. System (incl. Diarrhœa and Enteritis).	Dis. of Genito-Urinary System.	Dis. of Pregnancy and Child-birth.		Malforms under 1 year and Diseases of Early Infancy.	Senility.	Violence.	Miscellaneous.
		Principal Epidemic.	Other Infections.	Respiratory.	Other Tuberculous.		Cereb. Hæm., etc.	Other Nervous.		Pneumonia.	Bronchitis.	Other Respiratory.			Puerperal Sepsis.	Other Diseases.				
A.—Number of Deaths—Year 1952.																				
Under 1 year	90	—	1	—	—	1	—	5	—	11	1	1	1	1	—	—	59	—	6	3
1-4 years	13	1	1	1	1	2	—	—	—	1	1	1	2	—	—	—	—	—	1	1
5-14 ,,	17	—	1	—	1	4	—	1	—	—	—	—	2	—	—	—	—	—	5	3
15-24 ,,	22	—	1	2	1	1	2	—	2	—	—	—	2	2	—	—	—	—	7	2
25-34 ,,	38	—	1	3	—	11	1	1	10	1	1	—	1	—	—	—	—	—	8	—
35-44 ,,	87	2	—	4	—	29	5	4	13	1	2	—	4	4	—	2	—	—	14	3
45-54 ,,	180	—	1	10	—	57	13	3	58	1	2	2	6	1	—	—	—	—	14	12
55-64 ,,	334	1	5	10	1	84	39	5	134	8	7	3	12	7	—	—	—	—	8	10
65-74 ,,	576	2	2	6	—	128	100	7	217	13	20	4	18	14	—	—	—	2	19	24
75+ ,,	791	—	1	—	—	101	173	8	362	27	23	5	26	22	—	—	—	8	21	14
All Ages	**2148**	**6**	**14**	**36**	**4**	**418**	**333**	**34**	**796**	**63**	**57**	**16**	**74**	**51**	—	**2**	**59**	**10**	**103**	**72**
B.—Death-Rate per 100,000.																				
1952	1170	3	8	20	2	228	181	19	434	34	31	9	40	28	—	1	32	5	56	39

TABLE III.—ABERDEEN.—DEATHS AT ALL AGES FROM SELECTED CAUSES. (per 100,000 of population).—*Years* 1856-1952.*

Year.	Smallpox.	Scarlet Fever.	Diphtheria and Croup.	Measles.	Whooping Cough.	Influenza.	Typhus Fever.	Typhoid and Paratyphoid Fever.	Tuberc. Dis. Respiratory.	Tuberc. Dis. Other Tuberculosis.	Dis. of Digestive System (inc. Diarrhœa).	Cancer and other Malignant Diseases.	Bronchitis.	Pneumonia.	Diseases of the Circulatory System.
†1952 . . .	0	0	0	0	0	3	0	0	20	2	40	228	31	34	434
†1951 . . .	0	0	0	1	2	5	0	0	20	3	44	195	38	58	454
†1950 . . .	0	0	1	1	0	7	0	0	20	3	44	208	45	56	434
1949 . . .	0	0	0	1	0	5	0	0	32	3	44	182	43	58	414
1948 . . .	0	1	0	1	1	2	0	0	33	4	58	169	23	45	361
1947 . . .	0	0	0	2	3	1	0	1	35	6	90	177	38	59	402
Mean of 1947-51 .	0	0·2	0·2	1	1	4	0	0·2	28	4	56	186	37	55	413
1946 . . .	0	0	0	0	2	5	0	0	40	7	65	175	36	52	390
1945 . . .	0	0	6	2	2	4	0	0	43	9	64	177	35	44	383
1944 . . .	0	1	3	0	2	4	0	0	48	21	58	167	39	47	387
1943 . . .	0	1	3	1	2	28	0	0	46	17	78	189	48	57	386
1942 . . .	0	0	9	2	3	2	0	0	46	19	79	187	40	49	367
Mean of 1942-46 .	0	0·4	4	1	2	9	0	0	45	15	69	179	40	50	383
Mean of 1941-45 .	0	0·4	6	1	3	9	0	0·2	46	16	69	178	42	52	377
,, ,, 1936-40 .	0	1	11	4	7	15	0	1	41	11	69	160	50	73	331
,, ,, 1931-35 .	0	5	9	9	12	18	0	1	52	17	70	159	60	102	276
,, ,, 1926-30 .	0·2	2	10	11	11	21	0	0·2	62	30	78	145	61	100	240
,, ,, 1921-25 .	0	5	11	33	29	27	0	1	88	31	80	140	80	92	195
,, ,, 1916-20 .	0	6	16	22	23	73	0	3	106	43	87	121	99	122	178
,, ,, 1911-15 .	0·2	38	42	56	32	16	0	4	111	49	124	116	101	128	184
,, ,, 1906-10 .	0	6	15	26	42	20	0	2	116	61	115	103	105	116	180
,, ,, 1901-05 .	0·1	8	9	41	47	20	3	4	138	69	162	87	145	125	179
,, ,, 1896-1900 .	0	23	18	35	53	29	0	9	167	70	210	87	172	109	167
,, ,, 1891-95 .	0·4	21	22	63	52	56	1	10	181	72	190	81	210	100	156
,, ,, 1886-90 .	1	14	10	80	66	9	1	15	184	67	202	68	216	100	175
,, ,, 1881-85 .	0·2	13	15	36	67	1	6	13	204	74	185	69	251	82	159
,, ,, 1876-80 .	1	35	30	28	66	2	19	29	223	101	194	61	286	72	146
,, ,, 1871-75 .	48	68	30	53	68	5	20	35	243	107	214	56	281	60	136
,, ,, 1866-70 .	4	71	35	50	62	8	62	49	298	130	259	59	238	70	122
,, ,, 1861-65 .	36	93	49	51	62	12	176		274	128	280	57	220	59	122
,, ,, 1856-60 .	40	118	54	70	69	12	109		322	179	203	56	182	58	111

*Corrected for transferred deaths in 1904 and subsequent years.

† Causes of Death classified in accordance with Sixth Revision of International List of Causes of Death.

TABLE IV.—ABERDEEN.—MARRIAGE, BIRTH, AND DEATH RATE—1856 TO 1952. Per 1,000 of population.

Year	Population†	Marriages		Live Births *			Deaths *			Excess of Births over Deaths	Infantile Mortality
		Number	Rate per 1,000 of Population	Number	Rate per 1,000 of Population	Illegit Births per 100 Total Births	Number	Rate per 1,000 of Population	Average Age at Death		Deaths of Infants under 1 year per 1,000 Births
1952	183,626	1,929	10·5	3,025	16·5	5·7	2,148	11·7	64·6	877	30
1951	183,248	1.833	10·0	3,028	16·5	5·4	2,181	11·9	65·7	847	27
1950	187,961	1,853	9·9	3,226	17·2	5·3	2,266	12·1	64·9	960	29
1949	189.314	1,841	9·7	3,306	17·5	5·7	2,213	11·7	64·1	1,093	30
1948	188.853	2.104	11·1	3,598	19·1	5·9	2,098	11·1	61·7	1,500	34
1947	187,751	2,091	11·1	4,124	22·0	5·9	2,242	11·9	57·3	1,882	64
Mean of 1947-1951	187,425	1,944	10·4	3,456	18·5	5·6	2,200	11·7	62·7	1,256	38
1946	176,939	2,186	11·9	3,762	20·4	7·0	2,124	12·0	60·3	1,638	42
1945	163,108	2,286	12·5	2,830	15·5	10·0	2,084	12·8	59·6	746	54
1944	159,263	1,646	9·1	2,989	16·5	9·2	2,056	12·9	58·4	933	57
1943	159,162	1,700	9·5	2,876	16·0	8·9	2,239	14·1	57·5	637	68
1942	164,100	2,034	11·3	2,904	16·1	8·5	2,224	13·6	57·9	680	67
Mean of 1942-46	164,514	1,970	10·9	3,072	16·9	8·7	2,145	13·0	58·7	927	58
1941-1945	162,687	1,944	10·8	2,901	16·1	8·8	2,172	13·4	57·9	729	65
1936-1940	†	1,962	11·0	2,973	16·7	6·2	2,243	12·7	55·4	730	72
1931-1935	171,959	1,590	9·2	3.133	18·2	7·1	2,284	13·3	52·1	849	86
1926-1930	165,956	1,510	9·1	3,263	19·7	8·2	2,207	13·3	49·1	1.056	94
1921-1925	161,622	1,582	9·8	3,763	23·3	8·2	2,303	14·3	44·4	1,460	115
1916-1920	161,568	1,754	10·9	3,479	21·5	10·6	2,439	15·1	41·7	1,040	127
1911-1915	164,324	1,489	9·1	3,959	24·1	10·2	2,752	16·8	38·1	1,207	143
1906-1910	163,620	1,360	8·3	4,505	27·5	9·7	2,512	15·4	37·6	1.993	128
1901-1905	158,082	1,428	9·0	4,872	30·8	8·5	2,763	17·5	34·9	2,109	143
1896-1900	145,740	1,356	9·3	4,636	31·8	8·3	2,644	18·1	33·3	1,992	144
1891-1895	131,627	1,099	8·4	4,114	31·3	9·8	2.539	19·3	32·9	1,575	147
1886-1890	117,587	911	7·8	3,827	32·5	10·4	2,370	20·2	...	1,457	140
1881-1885	108,959	848	7·8	3,712	34·1	10·6	2,159	19·8	..	1,553	126
1876-1880	100,419	788	7·9	3,480	34·7	10·9	2,100	20·9	...	1.380	129
1871-1875	91,941	705	7·7	3,169	34·5	12·1	2,063	22·4	...	1,106	133
1866-1870	84,234	684	8·1	3,010	35·7	12·9	1,978	23·5	...	1,032	133
1861-1865	77,040	624	8·1	2,663	34·6	...	1,915	24·9	...	748	130
1856-1860	73,458	524	7.1	2,397	32·6	...	1,772	24·1	...	625	126

* Corrected for transferred births for 1911 and for transferred deaths for 1904 and subsequent years.

† Civilian Population from 1940 to 1946 inclusive used for death-rate only.

4.—MATERNITY AND CHILD WELFARE.

(*a*) EXPECTANT AND NURSING MOTHERS.

(i) Ante-natal Clinics.

Ante-natal sessions are held at one clinic equipped for ante-natal and post-natal work and at two child welfare centres in the City. At these clinics medical supervision is provided for women for whom institutional confinement has been arranged. (Such women constitute 85-90 per cent. of all expectant mothers in the City). In certain circumstances, women under the care of general practitioners and municipal midwives are also sent to the clinics for specialist consultation.

Co-operation of hospital consultants and of specialists in maternity and child welfare ensures that the best practicable advice is offered both on clinical and on medico-social matters, and the number of expectant mothers attending the clinics approximates very closely to the total number of births in the City, a fact which may well be causally related to the low still-birth rates, maternal death rates, and neo-natal death rates habitually obtaining in Aberdeen.

The weekly clinic sessions are as follows:—

Castle Terrace—4 sessions—Staffed by 1 consultant, 1 assistant medical officer of health, and 1 resident medical officer.

Castle Terrace—2 sessions—Staffed by 1 consultant and 1 resident medical officer.

Torry—1 session—Staffed by 1 assistant medical officer of health and 1 registrar.

Hilton—1 session—Staffed by 1 assistant medical officer of health and 1 registrar.

In addition to the medical staff, health visitors are in attendance at all clinics, and at the main centre (Castle Terrace) student midwives under the supervision of a trained midwife, a receptionist, and a clerkess are present. To prevent undue waiting, an appointments system operates at all clinics.

When an expectant mother visits a clinic for the first time she is immediately interviewed by a health visitor who explains the routine of the clinic. At this visit necessary particulars are recorded. The patient is next physically examined by one of the medical staff and is given, by the clerkess, an appointment for her subsequent visit.

At all ante-natal clinics, samples of blood are normally taken from every patient for performance of the Wassermann test and for measurement of hæmoglobin. In addition, a specimen of blood is examined for the Rhesus factor in the following cases:—

(*a*) all parous women without a previous live child;

(*b*) all parous women with a history of blood transfusion; and

(*c*) all third pregnancies and over.

(ii) Post-Natal Clinics.

At the Aberdeen Maternity Hospital, a specialist clinic is conducted weekly, and, in addition, post-natal clinics are held once weekly at Castle Terrace (Monday morning), Hilton (Thursday afternoon), and Torry (Monday afternoon) Child Welfare Centres. At the clinic at Castle Terrace, a consultant, an assistant medical officer of health, and a resident medical officer are in attendance, while at Hilton and Torry there are an assistant medical officer of health and a registrar who examine both post-natal and ante-natal cases during the weekly session.

At all clinics, health visitors give advice to the mothers on mothercraft, and a special clinic session is held once per week at the Castle Terrace Centre for this purpose.

(iii) Attendances at Ante-Natal and Post-Natal Clinics.

The following is a table showing the numbers attending and the number of attendances made at the ante-natal and post-natal clinics during 1952, with, for comparison, similar figures for 1951:—

	Ante-Natal Clinics.		Post-Natal Clinics.	
	No. of Women.	No. of Attendances.	No. of Women.	No. of Attendances.
1952 . .	2,874	21,237	1,786	2,065
1951 . .	3,058	19,658	1,674	1,771

(iv) Gynæcological Advisory Clinic.

This clinic is held at the Castle Terrace Centre, and a specially trained health visitor is in attendance from 9 a.m. to 5 p.m. from Monday to Friday. On Thursdays, an assistant medical officer of health is in attendance at the morning session and another assistant medical officer at the afternoon session. The number of mothers who attended during the year was 648, and they made 3,017 attendances.

(v) Supply of Maternity Outfits and Layettes.

A maternity outfit is supplied free of charge to each mother who is being confined at home. The contents of the outfit are as suggested by the Department of Health for Scotland.

Mothers are encouraged to provide their own layettes wherever possible, but a layette is supplied free in exceptional circumstances. In certain cases, mothers are given wool to make garments for the baby. Where a mother is entitled to receive Maternity Benefit, a charge of not less than £2 is made for a complete layette.

(vi) Arrangements for Care of Unmarried Mothers.

(i) *Aberdeen Mother and Baby Home.*

The Corporation have an arrangement with the Aberdeen Mother and Baby Home, Richmondhill House, King's Gate, which is conducted by a voluntary association, whereby accommodation is provided for expectant unmarried mothers. The Corporation make a payment of 35s. per week towards the maintenance of each woman whom they send to the Home. The women may be admitted and discharged at any time, but the Corporation's responsibility is limited to a period of six weeks before the expected date of confinement and four months thereafter. Women are not confined at the Home but at the Maternity Hospital. During the year, the Corporation accepted responsibility for 15 women admitted to the Home.

(ii) *Salvation Army Homes.*

Arrangements have been made whereby certain expectant unmarried mothers are sent by the Corporation to Salvation Army Homes in either Dundee or Glasgow. The payment made by the Corporation is 14s. per week for six weeks prior to the expected date of confinement, and 24s. per week for four months thereafter. During the year, 10 women were sent to the Salvation Army Homes.

In all, the Corporation made a contribution towards the maintenance of 25 unmarried mothers and their babies in the Mother and Baby Home or the Salvation Army Homes. The total number of illegitimate births for the City during the year under review was 172.

(*b*) CHILD WELFARE.

(i) *Child Welfare Centres.*

The Corporation have four full-time Child Welfare Centres at Castlegate, Charlotte Street, Hilton, and Torry, respectively. These are open daily from 9 a.m. to 5 p.m. with health visitors constantly in attendance, so that mothers may come at any time for advice. Clinic sessions are held for vaccination against smallpox, for immunisation against diphtheria and whooping cough, and for baby weighing and advice about care of children. Special morning sessions are reserved for giving advice to mothers on infant feeding. For examination of children by the medical staff, an appointments system has been introduced and functions satisfactorily, thus saving mothers from needless waiting.

A weekly clinic was held in Beechgrove Church Hall during the year, but the Corporation acquired, at No. 1A, View Terrace, premises which have been adapted for clinic work, and, from 5th December onwards, four sessions per week have been held in the new premises, the clinic at Beechgrove being discontinued. The centre serves the Rosemount area, and the numbers attending the centre in the last four weeks of the year show that such a clinic was much needed in that district.

In addition to the foregoing, weekly clinics are held at four other centres, viz.:—St. Machar's Church Hall; Powis Community Centre; the Lads' Club, Gallowgate; and Ruthrieston. A consultant or a registrar from the Aberdeen Hospital for Sick Children attends the Ruthrieston Clinic once fortnightly.

At Hayton, a clinic is conducted thrice weekly.

(ii) *Mobile Unit.*

On 7th July, a mobile unit, purchased at a cost of £3,371, was brought into operation. The unit—the first used for child welfare work in any town in Scotland—was specially designed to provide facilities for expert medical examination and for immunisation and vaccination in the minimum amount of space. It is staffed by an assistant medical officer of health and two health visitors. There is also a driver who, after uncoupling the unit from the van which tows it, is available for other duties during the time that the unit is operating at any one point.

The experiment has proved completely successful. The mobile clinic is functioning satisfactorily, and is providing in outlying areas facilities that would not otherwise be available.

In good and average weather the clinic was from the beginning eminently satisfactory. It has also met the test of bad weather, and, as was anticipated, the adequate heating of the unit presents some difficulties on very cold days, but endeavours are being made to overcome these difficulties.

The clinic operates at present in seven different areas, spending one half-day weekly in each. It may be of interest to set down the average numbers of medical consultations in each district for a period of five consecutive weeks. The five weeks chosen (one week of September and four of October) have been deliberately selected as representing a period in which the clinic had already become known to the public and the climatic conditions were neither especially favourable nor particularly unfavourable.

AVERAGE CONSULTATIONS, &C., PER SESSION FOR FIVE WEEKS.

Area.	Day.	No. of Children seen by Doctor.
Kaimhill . . .	Monday, p.m. . .	19
Stockethill . . .	Tuesday, a.m. . .	22
Smithfield . . .	Tuesday, p.m. . .	23
Holburn . . .	Wednesday, a.m. .	28
Inverdee . . .	Thursday, a.m. . .	12
Cummings Park . .	Friday, a.m. . .	15
Northfield . . .	Friday, p.m. . .	21

While the mobile unit is of very high value in providing facilities for skilled medical examination in those parts of the town that are in process of becoming built up, it cannot fully cope with the needs of a densely populated area. Its very success in areas like Holburn and Northfield demonstrates the need for clinics in these areas.

(iii) *Attendances at Child Welfare Clinics.*

The number of children who attended the child welfare clinics throughout the year, together with the number of attendances, was as follows:—

Total number of children under 5 years of age who first attended at the clinics during the year—

(*a*) Under 1 year of age, 2,222; (*b*) Over 1 year of age, 799.

Total number of attendances made by children during the year—

(*a*) Under 1 year of age, 27,729; (*b*) Over 1 year of age, 10,468.

(iv) *Facilities for Consultant Advice.*

Consultants do not attend at any of the Child Welfare Centres, but, if any condition is found on which expert clinical advice is required, the mother is told to take her child to her general practitioner who is advised of the condition, and may thereafter seek the advice of an appropriate consultant. The system works reasonably satisfactorily.

(v) *Ultra-Violet Light Clinics.*

Debilitated children, on the recommendation of an assistant medical officer of health, can receive ultra-violet light treatment at clinics which are held for that purpose twice weekly at the Hilton and Charlotte Street Centres.

(vi) *Orthopædic Clinics.*

Arrangements have been made with the Principal of the Dunfermline College of Physical Training whereby the medical staff may send children suffering from postural defects to the College at Woolmanhill where remedial exercises are given. This arrangement, in addition to being highly beneficial to the children, is very useful to students.

Pre-school children suffering from other orthopædic defects are referred to an orthopædic clinic which is now also held at Woolmanhill. The children attending this clinic are seen by an orthopædic surgeon employed by the North-Eastern Regional Hospital Board.

(*c*) CARE OF PREMATURE INFANTS.

All premature babies born at home are forthwith transferred to the Babies' Nursery at the Aberdeen Maternity Hospital. This enables such babies to secure skilled medical attention and continuous nursing, and gives them the best chance of survival. When it is considered that the babies can safely be sent home, the Health and Welfare Department is notified, and the appropriate health visitor immediately visits the home to ensure that everything necessary is done for the baby. In certain instances, equipment, such as cots, cot blankets, &c., is issued on loan, and the health visitor gives special instruction to the mother on the care of the baby.

(*d*) SUPPLIES OF DRIED MILK, &c.

By arrangement with the Ministry of Food, cod liver oil, orange juice, and National dried milk are issued at all Child Welfare Centres, and vitamin A and D liquid (Adexolin) is distributed free of charge to necessitous cases.

Certain proprietary milk foods are also issued at reduced prices at the discretion of the assistant medical officer of health at each clinic.

(*e*) DENTAL CARE.

The authorised establishment in the dental section is one chief dental officer, one senior dental officer, and five dental officers, *i.e.*, seven individuals, and at 1st January there were four vacancies. Repeated advertisements made it possible to recruit another dental officer as from 25th August, 1952. Accordingly, at the end of the year there were three vacancies on the establishment. Unfortunately, one of the dental officers has been off duty since 29th September, 1952, and was still off at the end of the year, so that the work of the section throughout most of the year was carried out by only three dentists, and this shortage of staff limited the work which could be carried out. An approach was made to the Aberdeen Local Dental Committee (as already mentioned) to ascertain whether dentists in practice would be willing to assist the local authority in dealing with school children and expectant and nursing mothers and pre-school children, either on a part-time or on a sessional basis. The Local Dental Committee, however, considered that, as they already gave a measure of priority to the classes mentioned, they could not give any further assistance. It was accordingly not possible for the depleted staff to attend to all the cases brought to their notice, and this is very much regretted. The importance of the dental care of expectant and nursing mothers cannot be over-estimated, as has been stressed by the Chief Dental Officer of the Department of Health for Scotland in a survey of the position of local authorities' dental services at the end of 1952.

To such extent as staffing shortages permit, patients are referred to the dental clinic by the assistant medical officers of health who examine expectant mothers and young children at the ante-natal and child welfare clinics, respectively. The following figures show the work which the dental officers undertook during the year, data for 1951 being given in parenthesis for purposes of comparison:—

	Examined.	Found to need Treatment.	Treated.
Expectant and nursing mothers	0 (0)	0 (0)	0 (0)
Pre-school children	12 (82)	12 (82)	12 (62)

In other words, the local authority dental service in respect of these categories is virtually non-existent.

It must be made clear that no blame for this lack of services attaches to the Corporation. The lack is caused by inability to secure staff despite advertisement

(*f*) OTHER PROVISIONS FOR EXPECTANT AND NURSING MOTHERS AND YOUNG CHILDREN.

(i) Residential Nurseries.

The Corporation have two residential nurseries—one at Thorngrove Home, which has 21 places, and the other at Pitfodels House, which has accommodation for 50 children. Both nurseries are recognised for the training of nursery students. An extension to Pitfodels House was in process of completion at the end of the year, and, when this is completed, it will be possible to transfer all the children to Pitfodels, freeing Thorngrove for other purposes.

The residential nurseries are for the children of parents who, for an adequate reason, such as mother in hospital, cannot look after their young children. Children taken into the care of the Local Authority and under two years of age are also accommodated in one or other of these homes.

(ii) Day Nurseries.

At present the Corporation provide four day nurseries—Charlotte Street (with 60 places), View Terrace (44 places), Torry (40 places), and Linksfield (30 places). All four have been recognised for training purposes. The Linksfield Nursery continues to be situated in Linksfield School, although the Corporation have actually acquired a piece of ground in King Street upon which it is proposed ultimately to erect a new day nursery. As a temporary measure, more suitable accommodation is being obtained in the school, and, after certain minor alterations, the children will be transferred to that accommodation. As an experiment, it has been decided to appoint at Linksfield, a nursery warden who is a qualified teacher holding the Nursery Schools Endorsement. The Corporation have also, at the end of the year, approved of a small extension to Torry Day Nursery, and it is hoped that this extension will be completed during 1953.

5.—DOMICILIARY MIDWIFERY.

General.

The Corporation's Domiciliary Midwifery Scheme under the Maternity Services (Scotland) Act, 1937, was modified in 1948 because practitioners were subsequently employed and recompensed by the Executive Council and not by the Corporation.

The midwifery staff consists of a Supervisor of Midwives (who is also the Superintending Nursing Officer) and eight whole-time midwives. A district of the City is allocated to each midwife. In addition, the Corporation have an arrangement with the Board of Management for the Aberdeen Special Hospitals whereby a central district of the City is served by three midwives on the staff of the Aberdeen Maternity Hospital, and the Corporation pay £750 per annum towards the remuneration of these midwives. The small number of midwives is explained by the fact that the majority of confinements in Aberdeen take place in hospital.

The Supervisor of Midwives is responsible for the supervision of all practising midwives in the City—not only those on the staff of the Corporation. At present, there is one midwife in private practice in the City, and sixty-one midwives are employed in hospitals or nursing homes. During the year there was only one confinement where a private practising midwife was in attendance, 316 confinements were attended by municipal midwives and 101 confinements by midwives employed by the Board of Management for the Aberdeen Special Hospitals.

Births.

Particulars of the births, including still-births, which occurred in the City during 1952 are as follows:—

(i) Total number of births occurring in the area during year—that is, before correction for mothers' residence :—Live births, 3,658; still-births, 99. Total	3,757
(ii) Total number of above births occurring in institutions (including private maternity homes)	3,334
(iii) Total number of above births occurring at home	423

These 423 may be further subdivided thus to show attendance at birth :—

	Doctor engaged and present.	Doctor engaged but not present.	No doctor engaged.	Total.
Municipal midwives	35	279	2	316
Hospital midwives "on district"	6	76	19	101
Private practising midwives	1	—	—	1
No midwife	2	—	3	5

Administration of analgesics.

Ten domiciliary midwives are qualified to administer gas and air analgesia; two sets of gas and air apparatus were in use at 31st December, and a third set was on order; and gas and air analgesia was administered by midwives in 329 cases during the year, while pethedine was administered in 176 cases.

Use of cars.

At the end of the year no municipal midwife had a car.

Arrangements for ante-natal supervision by Midwives.

When a confinement is to take place at home, ante-natal supervision is given by the midwife concerned either in a duty room set aside for that purpose in the midwife's house or at the woman's own home. This supervision is given from the time of booking the midwife, and visits are paid to the woman's own home weekly during the last month. If any personal or environmental circumstances make it desirable that a confinement, originally booked as domiciliary, should in fact take place in hospital, the general practitioner and the midwife advise the woman accordingly. Wherever possible, however, arrangements for admission to hospital on social grounds are made early in the pregnancy.

Refresher Course for Midwives.

During the year a refresher course for midwives was held in Aberdeen. This course was conducted under the auspices of the Royal College of Midwives and the Queen's Institute of District Nursing. The course extended from 25th March to 2nd April, and, in addition to the midwives who were free to attend, many health visitors attended. It was not possible for all the staff to attend for the full course, but it was arranged that various members should attend selected lectures which would be of particular interest to them in their branch of work.

Training of Pupil Midwives.

The Aberdeen Maternity Hospital is, of course, a training hospital, but, as part of their training, midwives must have training in domiciliary confinements. This is arranged through three midwives stationed at Castle Terrace, and the Supervisor of Midwives gives lectures to the students before they begin their domiciliary work.

6.—HEALTH VISITING.

General.

Under Section 24 of the National Health Service (Scotland) Act, 1947, the Corporation have a duty to make provision for the visiting of persons in their homes by health visitors for the purpose of giving advice on the care, not only of expectant and nursing mothers and young children, but also of persons suffering from illness, and on the measures necessary to promote health and to prevent the spread of infection. The duties of health visitors are, accordingly, very much wider than they were before 1948. Instead of being concerned simply with the care of children and the prevention of infectious disease, the health visitor is now a recognised health adviser of the whole family, concerned with general promotion of physical and mental fitness, prevention of disease, and advising on the care and after-care of the sick. She is the person to whom a housewife can turn for advice on family budgeting, household economics, dietetics, personal hygiene, and matters relating to the health of all members of the family. Owing to shortages of health visitors, it has not as yet been possible fully to cope with all the new duties, but (in addition to continuation of the older functions in relation to the care of young children and expectant and nursing mothers) many additional tasks are already undertaken. A few points may be selected for mention here. Where a premature baby is returned from the Maternity Hospital to its home, the appropriate health visitor immediately calls and, if deemed necessary, daily visits are paid to give advice to the mother with a view to ensuring that everything possible is done to enable the baby to become a healthy child. Again, health visitors devote much time and energy to encouraging mothers to have their children vaccinated against smallpox and immunised against diphtheria and whooping cough. Then again, the health visitors give weekly talks to the mothers on "Health Education" at the four full-time clinics—these talks being in addition to monthly lectures given by Assistant Medical Officers of Health.

An aspect of health visiting which developed considerably during the year was the visitation of old people. At the end of the year, regular visits were being paid to some 200 elderly persons.

In Aberdeen, to enable nurses to get to know more closely the families that they are advising, and to save any one household from receiving visits from several nurses, health visitors also act as school nurses, and it is intended that they should, in addition, act as welfare visitors in respect of cripples and handicapped persons.

In order to provide an efficient health visiting service, the Corporation decided in 1951, as an interim measure, to increase the establishment of health visitors to 65 and obtained the sanction of the Secretary of State for an ultimate establishment of 100. The increase in numbers actually employed is gradually taking place. At the end of 1952, there were 52 health visitors in the employment of the Corporation.

These included five doing tuberculosis work and one working largely in connection with infectious diseases.

Visitation by Health Visitors.

An analysis of the number of home visits made by health visitors during the year is given below, the total visits for 1951 being also given for purposes of comparison:—

	No. Visited.	Total Visits.	Total Visits in 1951.
(*a*) Maternity and Child Welfare—			
Expectant mothers . .	2,206	7,335	5,417
Children under 1 year . .	3,001	31,797	31,275
Children aged 1-5 years .	10,998	46,039	51,551
(*b*) Cases of tuberculosis . .	1,220	7,002	5,645
(*c*) Other cases	4,828	5,015	3,692

It must, of course, be appreciated that, in addition to the 97,188 visits mentioned above, much of the work of the health visitors is carried out at Child Welfare Centres throughout the City. In point of fact, nearly 30 per cent. of their time is spent in clinic work and about another 20 per cent. in schools.

Liaison with Hospitals.

This is very close in the case of some hospitals, *e.g.*, the Maternity Hospital (from which intimation of discharge of patients is always passed to the department and full particulars made available), the infectious diseases hospital, and the tuberculosis hospitals (in respect of which five health visitors undertake work which might otherwise be done by hospital almoners). In other cases, however, the liaison is less close, although attempts are being made to extend and increase it.

It is probably inevitable that, when a patient goes to hospital as a result of sudden illness, the local authority are not made aware of that fact (except in cases of notifiable disease), although in at least a proportion of cases the local authority might be able to provide information of value to the hospital or concrete assistance to relatives of the patient. What is certainly far from inevitable—and therefore highly distressing—is that patients should be discharged from hospital without any notification to the local authority, which is consequently rendered unable to carry out its statutory tasks of care and after-care.

Liaison with General Practitioners.

All degrees of co-operation and lack of co-operation are found but, in general, the amount of liaison between general practitioners on the one hand and health visitors on the other is increasing. A factor which may stimulate further increase in co-operation is the new development of using health visitors in the practical training of medical undergraduates.

Refresher Course for Health Visitors.

During the year, a refresher course was held under the auspices of the Royal College of Midwives and reference is made to this course under the section dealing with midwifery.

Training of Health Visitors.

In 1948, the Corporation inaugurated a training course whereby state registered nurses with the necessary midwifery training could obtain the knowledge to enable them to take the examination for the health visitors' certificate. Since that time, six courses have been held, including the course which commenced in October, 1952. Each course extends over a period of six months of full-time study. These courses have proved most beneficial for the recruitment of health visitors to the Corporation's service, a point of great importance in the existing scarcity of these officers. The number of students trained each year and the number recruited by the local authority were as follows:—

Year.	Total Number of Students.	Number Subsequently Employed by Corporation.
1948	20	6
1948-49	20	8
1949-50	19	7
1950-51	21	9
1951-52	19	7
1952-53	20	Still in training

The lecturers in these courses were medical members of the staff of the Health and Welfare Department; professors and lecturers of Aberdeen University; medical specialists employed by the North-East Regional Hospital Board, and several others, and a qualified health visitor tutor is employed to supervise the practical and theoretical training of the nurses.

Limitations of Staff.

As was stated in the Report for 1951, and as already mentioned on page 34, the Corporation has obtained the sanction of the Secretary of State for an ultimate establishment of 100 health visitors, and has authorised an immediate establishment of 65, but, owing to shortages, the number actually employed at 31st December was 52. This scarcity naturally limits the extent to which new services can be developed. The need in such circumstances is not to decide between what is desirable and what is unnecessary, or even to decide between the highly desirable and the desirable, but rather to allocate priorities between things which are all highly desirable and perhaps essential.

7.—HOME NURSING.

General.

The Corporation carry out their duty to secure the attendance of nurses on persons who require nursing in their own homes through the agency of the Aberdeen District Nursing Association, the expense thereof being met by the Corporation. The Lord Provost, the Treasurer, the Convener of the Health and Welfare Committee, and one other Councillor, together with the Medical Officer of Health are members of the Committee of the District Nursing Association.

Co-operation.

As would be expected, most of the cases dealt with by the nurses employed by the Nursing Association are referred to them by the general practitioners in the City, although quite a proportion are discovered by the health visitors and referred through the Health and Welfare Department.

In a number of cases where a patient is discharged from hospital and requires nursing attention, an almoner at the hospital contacts the Superintendent of the Nursing Association to arrange for a nurse to provide that attention.

Again, there is a standing arrangement that each month a list of old people who are convalescent and no longer requiring nursing attention is furnished by the Nursing Association to the department, so that appropriate health visitors can pay periodic visits to the old people to ensure that they are getting all the assistance they need, *e.g.*, home helps, meals on wheels, &c.

Classification and proportions of main types of cases.

The classification and proportions of the main types of cases dealt with by the nurses employed by the Nursing Association are as follows:—

Classification and Proportions of Main Types of Cases Nursed in 1952.

DAY NURSING SERVICE.

Diseases	No. of Patients			No. of Visits			Age		Termination of Cases			
	M.	F.	Total	M.	F.	Total	-65	65+	Conv.	Transfer to Hosp.	Died	Continuing at 31st Dec.
Abdominal .	297	461	758	3,681	4,843	8,524	468	290	626	65	26	41
Accidents . .	98	151	249	1,222	2,653	3,875	171	78	207	11	12	19
Amputations .	8	8	16	255	125	380	11	5	13	—	1	2
Anæmia . .	9	43	52	131	1,022	1,153	15	37	16	2	3	31
Cancer . .	69	133	202	1,875	3,457	5,332	105	97	47	18	123	14
Cardiac . .	91	154	245	1,188	4,336	5,524	91	154	87	67	36	55
Cerebral Hæm. .	95	154	249	2,763	4,782	7,545	59	190	63	23	112	51
Diabetes . .	13	67	80	1,707	10,250	11,957	18	62	30	8	5	37
Gynæcological .	—	76	76	—	877	877	49	27	66	4	1	5
Miscellaneous .	559	1,091	1,650	7,970	16,439	24,409	1,161	489	1,186	104	115	245
Nervous . .	21	29	50	972	1,203	2,175	34	16	17	8	10	15
Respiratory .	169	165	334	1,510	1,572	3,082	226	108	257	36	27	14
Rheumatism .	8	71	79	330	3,115	3,445	36	43	25	12	10	32
Varicose Ulcers	11	64	75	706	3,794	4,500	31	44	41	5	3	26
Total .	1,448	2,667	4,115	24,310	58,468	82,778	2,475	1,640	2,681	363	484	587

Night Nursing Service.

After prolonged negotiations with the District Nursing Association, a Night Nursing Service was inaugurated on 15th January, 1952, and has already proved most useful. The main function of the Night Nursing Service will probably be the provision of occasional skilled nursing (*e.g.*, visiting patients for four-hourly injections of penicillin or for injection of pain-killing drugs), but, in its initial stages, it has served mainly to provide nursing care for persons living alone or for persons whose relatives were exhausted from looking after the patient on previous nights. The service, at the end of 1952, could still be regarded as in its infancy. In December, the staff employed on night work amounted to one trained nurse and three assistant nurses on a full-time basis, four trained nurses on a part-time basis, and a night telephonist. In all, 175 cases were attended during the year. At the end of the year consideration was being given to the possibility of instituting an alternative arrangement whereby the services of a night telephonist would no longer be required. Details are given in the following table:—

NIGHT NURSING SERVICE.

Diseases	No. of Patients			No. of Visits			Age		Termination of Cases			
	M.	F.	Total	M.	F.	Total	-65	65+	Conv.	Transfer to Hosp.	Died	Continuing at 31st Dec
Abdominal . .	3	7	10	9	80	89	5	5	4	—	6	—
Anæmia . .	1	—	1	7	—	7	1	—	—	—	1	—
Cancer . .	8	20	28	35	237	272	11	17	1	1	24	2
Cardiac . .	10	15	25	30	114	144	8	17	9	5	10	1
Cerebral Hæm. .	16	21	37	106	198	304	7	30	10	5	21	1
Miscellaneous .	9	13	22	103	145	248	2	20	16	2	4	—
Nervous . .	3	2	5	14	9	23	1	4	—	1	3	1
Respiratory .	4	3	7	7	133	140	3	4	2	1	4	—
Rheumatism .	—	5	5	—	65	65	—	5	—	1	4	—
Senility . .	5	30	35	141	451	592	1	34	9	4	18	4
Total . .	59	116	175	452	1,432	1,884	39	136	51	20	95	9

Training of District Nurses.

The Association undertakes training for the Queen's Certificate. At the end of the year five students were receiving training.

8.—DOMESTIC HELP SERVICE.

Under the National Health Service Act, the Corporation provide a home help service. Households which may qualify for this help include those where there is a sick person; an expectant mother; an elderly person; and certain other categories. A charge is made for the home help, and is based on the applicant's income.

The present establishment of home helps is 80, but the approval of the Secretary of State has been obtained to the ultimate increase of the number employed to 200.

The following is a table showing the number of home helps in the service at December, 1952, as compared with December, 1951:—

	1952.	1951.
Whole-time . . .	36	35
Part-time . . .	39	27

It will be noted that there has been a very slight extension during the year.

The following statement shows the distribution of the cases attended during 1952:—

(*a*) Maternity and Child Welfare cases . .	207
(*b*) Infirm and elderly cases (over 65) . .	225
(*c*) Long-term illnesses (other than (*b*)) . .	32
(*d*) Short-term illnesses (other than (*a*) or (*b*)) .	343

9.—VACCINATION AND IMMUNISATION.

(1) VACCINATION AGAINST SMALLPOX.

As civilisation progresses, persuasion can often replace compulsion. Vaccination against smallpox is as necessary as ever, or perhaps more necessary than ever, in view of the increased possibilities of infection consequent on the spread of air travel, but since 1948 compulsory vaccination has been abolished and reliance placed on the persuasive efforts of the local authority. In all clinics and also in the course of their visits to the infant's home, the health visitors impress upon each mother the necessity of having her baby vaccinated against smallpox. The actual vaccination is performed either by the child's general practitioner (who receives a standard fee for notifying vaccination to the local authority) or by doctors at child welfare clinics (where special sessions are held for immunisation and vaccination).

Of 2,381 primary vaccinations during 1952, 1,471 were notified by general practitioners and 910 were done at local authority clinics. The following table gives an analysis of primary vaccinations by year of birth and type of reaction:—

Analysis of Primary Vaccinations.

Year of Birth	Typical Vaccinia greatest at 7th-10th day	Accelerated (Vaccinoid) Reaction 5th-7th day	Greatest Reaction 2nd-3rd day	No Local Reaction	Total
1952	1,238	6	4	20	**1,268**
1951	905	4	9	13	**931**
1950	77	2	...	2	**81**
1949	24	...	1	...	**25**
1948	16	...	...	...	**16**
1947	7	...	...	..	**7**
1946 . -	1	...	...	...	**1**
1945	1	...	...	..	**1**
1944	...	...	...	...	...
1943 or earlier . . .	50	1	...	...	**51**
Totals . . .	**2,319**	**13**	**14**	**35**	**2,381**

When vaccination was compulsory, about 85 per cent. of children in Aberdeen were actually successfully vaccinated; the Registrar-General's report for 1947 gives the figure of 85·1 per cent. for children born during 1946. For children born in 1951, the proportion successfully vaccinated by the end of 1952 was 70 per cent. and from the table it would appear that this figure is likely to be maintained in the case of children born during 1952.

For propaganda purposes, reliance is placed almost exclusively on the influence of the health visitors.

(2) IMMUNISATION AGAINST DIPHTHERIA.

(a) Cases of Diphtheria.

The 1951 record of no cases during an entire year was not maintained; in 1952, there were three cases of diphtheria. There has been no fatal case of diphtheria in the City since 1950, in which year an unimmunised child died.

(b) Propaganda employed for Primary Immunisation.

As in the case of vaccination against smallpox, the health visitors make a great effort to ensure as far as possible that all children are immunised against diphtheria in their first year of life. This effort is not confined to the clinics but is also made in the people's homes. Leaflets are handed out and posters are displayed at the clinics but it is felt that the personal approach by the health visitor is the point of supreme value.

(c) Re-immunisation.

A further effort is made to secure that as many as possible receive a reinforcing dose either just before going to school for the first time or in their first year at school; and a second reinforcing dose is available about three years later.

(d) Numbers immunised.

The numbers of individuals who completed a full course of immunisation or who received a reinforcing injection during 1952 are given in the accompanying tables. Figures for 1951 are also provided for purposes of comparison.

DIPHTHERIA IMMUNISATION.

	1952		1951	
	Primary Immunisation	Reinforcing Dose	Primary Immunisation	Reinforcing Dose
Number Immunised—				
(*a*) By General Practitioners . .	1,168	204	1,247	127
(*b*) At Child Welfare Clinics . .	1,162	137	1,121	98
(*c*) By School Health Service . .	937	3,600	812	2.985
	3,267	**3,941**	**3,180**	**3.210**

In other words, just over one-third of primary inoculations are carried out by general practitioners and just over one-third by doctors at child welfare clinics. Nearly a third of primary inoculations are undertaken at school (about four years late), and the school health services also carries out over 90 per cent. of the reinforcing injections.

A more detailed break-down of the immunisations performed during 1952 is given in the next table.

Diphtheria Immunisation Analysis for year 1952.

	YEAR OF BIRTH																
	1952	1951	1950	1949	1948	1947	1946	1945	1944	1943	1942	1941	1940	1939	1938	937 or earlier	Total
Primary Immunisation.																	
Number Immunised—																	
(*a*) By General Practitioners .	59	790	206	43	25	24	11	3	1	1	...	...	...	...	..	5	1,168
(*b*) At Child Welfare Clinics .	110	720	141	68	37	47	31	2	2	4	...	...	...	...	...	...	1,162
(*c*) By School Health Service .	...	1	4	4	10	210	521	11	3	166	3	2	2	...	...	..	937
Total Number of Children fully Immunised . , . . .	169	1,511	351	115	72	281	563	16	6	171	3	2	2	...	...	5	3,267
Reinforcing Dose.																	
(*a*) By General Practitioners .	...	...	...	1	13	86	53	11	3	18	4	6	...	1	...	8	204
(*b*) At Child Welfare Clinics .	..	...	...	...	26	96	11	1	...	3	...	...	...	...	...	...	137
(*c*) By School Health Service .	...	...	...	1	2	545	1,243	17	23	1,741	6	10	12	...	...	...	3,600
Total Number of Children who have received a maintenance injection	...	...	...	2	41	727	1,307	29	26	1,762	10	16	12	1	...	8	3,941

(e) Percentage of Pre-school children who were Immunised against Diphtheria at end of 1952.

At the end of the year, 51 per cent. of all pre-school children were recorded as being immunised. It is most desirable that this figure be raised by a very considerable amount.

(3) IMMUNISATION AGAINST WHOOPING COUGH.

The Department of Health for Scotland have not yet given official approval to any vaccine as thoroughly efficacious but, in spite of this, the Corporation—which carried out diphtheria immunisation for sixteen years before that form of protection was officially accredited—undertakes immunisation against whooping cough at the child welfare clinics. The health visitors encourage all mothers to have their children immunised either at the clinics or by their own general medical practitioners.

The following summary gives the numbers immunised against whooping cough during 1952:—

By general practitioners . .	1,001
At clinics	886
Total . .	1,887

(4) IMMUNISATION AGAINST TUBERCULOSIS.

Immunisation of contacts is carried out under the direction of the Chest Physician at the City Hospital, although a small amount of skin testing is carried out at child welfare clinics.

(5) OTHER IMMUNISATIONS.

Persons going abroad to certain countries need to be immunised against such diseases as yellow fever, &c., and this immunisation is normally carried out at the City Hospital.

10.—PREVENTION OF ILLNESS, CARE, AND AFTER-CARE.

(A) TUBERCULOSIS.

(a) General.

The broad division of responsibility for the treatment of tuberculosis is that the provision of institutional care and specialist services are the concern of the Regional Hospital Board, while all functions relating to prevention, care, and after-care are in the hands of the local authority. Some of the latter functions may be briefly outlined—

(i) Contact tracing and follow-up. Notification of a case may come from a general practitioner, but usually comes from a chest consultant to whom the patient has been referred by the practitioner. Immediately a case is notified, the health visitor for the area visits the home and ascertains the number of persons in the house, sleeping accommodation, family medical history, &c.; and endeavours are made to have all members of the household radiologically examined at the City Hospital. This follow-up of all cases is of greatest value and may be the means of other members of the household keeping clear of the disease. It is also of profound epidemiological importance : tuberculosis is spread mainly by unsuspected, undiagnosed persons.

(ii) Co-operating with Regional Hospital Board and with general practitioners in determining the need of patients for admission to hospital. The Senior Chest Physician acts in respect of preventive work as an honorary member of the staff of the department, with five health visitors seconded to him. He, therefore, has at his disposal his own clinical record, a comprehensive report submitted by the health visitor on home circumstances, and any information made available to him by general practitioners. Hence he is in a very strong position to make a sound decision about the relative need for the admission of different patients to hospital.

(iii) Assisting households with a tuberculous member to obtain adequate accommodation. The Corporation, some time ago, adopted a policy whereby tenancy of Council houses is, in appropriate cases, granted to persons suffering from "open" tuberculosis, so that segregation of the infectious case can be made. It will be appreciated that, with over 200 cases of tuberculosis notified annually, it is not practicable to allot houses to all tuberculous patients.

(iv) Advice to persons suffering from tuberculosis and living at home is given by the health visitors. This advice covers the proper segregation of the patient from the rest of the household and the precautions which should be taken with a view to improving environmental hygiene, maintaining general health, increasing resistance, and generally ensuring that the remainder of the household do not contract tuberculosis.

(v) Arranging, where necessary, for boarding-out of child contacts. Under the Corporation's Proposals for the Discharge of Functions, arrangements are made whereby child contacts can be sent to Linn Moor Home, Culter, a convalescent home run by a voluntary organisation. The Corporation, of course, make a payment in respect of the boarding-out of such child contacts. The period of residence in Linn Moor Home varies according to the health of the child.

(vi) Providing beds, bedding, and nursing requisites. In certain circumstances, a loan is given of beds and bedding, on the recommendation of the Chest Physician after the health visitor has submitted a report on the home conditions.

(vii) Co-operating with Ministry of Labour in resettlement of tuberculous persons in employment or in their entry to sheltered employment. With regard to the resettlement of tuberculous persons, the Chest Physician is in close contact with the Ministry of Labour and National Service to ensure that patients who have suffered from tuberculosis obtain employment suitable to their condition. The Corporation also send patients to Papworth Village Settlement and to the British Legion Village at Preston Hall, where tuberculous patients unfit for their previous occupation may obtain training in other occupations.

(b) Co-ordination with diagnostic and curative service.

By arrangement with the Regional Hospital Board, the Senior Chest Physician and his staff are available for the medical supervision, under the administrative control of the Medical Officer of Health, of the operation of the Corporation's arrangements. When discharging functions under these arrangements, the physician is regarded as having the status and responsibilities of a Deputy Medical Officer of Health (Tuberculosis); and—as indicated above—a number of health visitors are employed full-time on tuberculosis work and operate under the direction of the Chest Physician. The number was increased to five during the year.

In practice, co-ordination is extremely good. When a case of tuberculosis is notified to the Medical Officer of Health by a general practitioner. the notification is forthwith intimated to the Chest Physician, and where a suspected case is referred by the practitioner to the Chest Physician, the notification is made by that officer whenever diagnosis is complete. Moreover, where deemed desirable, action can be taken in advance of any formal notification. A sanitary inspector's report and a health visitor's report are made available so that the Chest Physician has full information on clinical state, family circumstances, housing conditions, &c., In the light of the full information, the Chest Physician is enabled to reach decisions about the patient's admission to hospital. Contacts, as already mentioned, are followed up by local authority health visitors and urged to attend for examination by the Chest Physician, and health visitors advise patients about hygienic aspects when living at home, about allowances and help available. When discharge of a patient from hospital is contemplated, the Medical Officer of Health is notified of any particular needs.

(c) Examination of contacts.

The family of a patient is regarded as a unit and, as already stated, an endeavour is made to have all members of the family radiologically examined at the City Hospital. The patient's family does not always fully co-operate with the health visitors, but it is interesting to note that, during the year under review, 1,433 contacts were examined. The following tables give the number of contacts who, during the year, were clinically examined; skin tested; vaccinated; and found to have tuberculosis.

NUMBER OF CONTACTS EXAMINED IN 1952.

SEX	AGE GROUPS							TOTALS
	0—1	1—5	5—10	10—15	15—20	20—25	25+	
M	50	135	88	92	95	50	124	634
F	44	125	102	128	156	80	164	799
Total	94	260	190	220	251	130	288	1,433

Number of Contacts Skin Tested in 1952.

		AGE GROUPS.							
	Sex.	0-1.	1-5.	5-10.	10-15.	15-20.	20-25.	25+	Totals
Result −ve .	M.	47	69	43	35	9	—	—	203
+ve .	M.	1	15	12	8	4	—	—	40
−ve .	F.	41	74	43	39	12	—	—	209
+ve .	F.	1	11	4	20	6	—	—	42
Totals . .	M.	48	84	55	43	13	—	—	243
	F.	42	85	47	59	18	—	—	251
Total . .		90	169	102	102	31	—	—	494

Number of Contacts Vaccinated.

	AGE GROUPS.							
Sex.	0-1.	1-5.	5-10.	10-15.	15-20.	20-25.	25+	Totals.
M. .	39	56	35	24	4	—	—	158
F. .	41	55	35	25	9	—	—	165
Total	80	111	70	49	13	—	—	323

Number of Cases of Tuberculosis Found among Contacts.

1952	AGE GROUPS											Totals
	0—1	1—2	2—5	5—10	10—15	15—20	20—25	25—35	35—45	45—55	55+	
M	2	—	2	3	1	1	4	2	—	1	—	16
F	1	1	2	—	1	8	1	4	—	1	—	19
Total	3	1	4	3	2	9	5	6	—	2	—	35

(d) B.C.G. Vaccination.

The following is a copy of the return which was submitted to the Department of Health, giving particulars of the B.C.G. vaccinations performed:—

B.C.G. Vaccinations Performed.

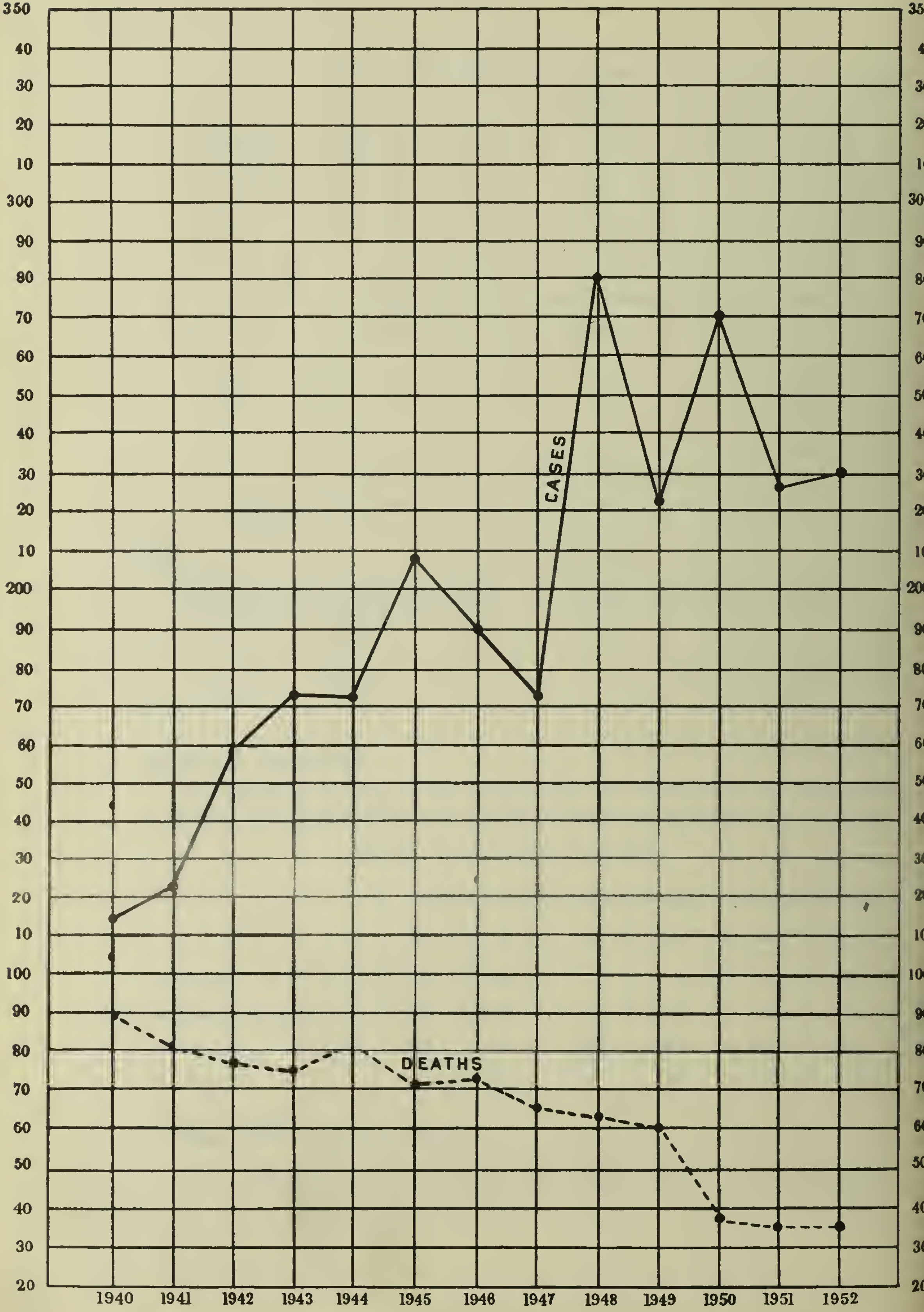
GROUP	Tuberculin Tested		Negative Re-actors		Successfully Vaccinated.	
	M.	F.	M.	F.	M.	F.
(*a*) Nurses	5	270	2	78	2	75
(*b*) Medical Students . .	64	23	17	8	15	8
(*c*) Contacts . . .	243	251	203	209	158	165
(*d*) Others	62	89	37	35	3	9

(e) Mass Miniature Radiography.

It was hoped that the Mass Miniature Radiography Unit of the Regional Hospital Board would commence large scale operations during 1952, but at the end of the

---

CASES AND DEATHS FROM RESPIRATORY TUBERCULOSIS, 1940-1952



year intimation was received that it was going to commence operation early in 1953. Meantime, it is the practice of the Corporation that all new employees liable to come into close contact with young children, are radiologically examined before appointment. The Corporation also desire that such people should be radiologically examined at least once annually, but, owing to shortage of x-ray films, this is not at present possible.

(f) Supply of extra nourishment.

Extra nourishment (such as cod liver oil and milk) is given to necessitous cases on the recommendation of the Chest Physician. It is interesting to note that an average sum of £1,400 is spent on the supply of milk on such cases.

(g) Notification.

Table A gives the number of tuberculous cases notified during 1952 and, for comparative purposes, the figures for 1951 are also given. These are divided into respiratory and non-respiratory and arranged according to age-period and sex.

TABLE A.—NUMBER OF CASES OF TUBERCULOSIS NOTIFIED IN 1952.

	NUMBER OF CASES NOTIFIED AS SUFFERING FROM TUBERCULOSIS.										Cases removed to hospital.	Cases notified in a previous year and removed to hospital for the first time during 1952.
	AGE-GROUPS.											
	Under 1	1-5.	5-10.	10-15.	15-25.	25-35.	35-45.	45-65.	65 upwards.	TOTAL.		
RESPIRATORY.												
1952 Males	1	5	8	6	16	18	15	37	5	**111**	100	1
1951 Males	*2*	*7*	*4*	*4*	*28*	*24*	*20*	*24*	*10*	*123*	*104*	*6*
1952 Females	1	3	5	7	55	17	19	10	2	**119**	108	7
1951 Females	*1*	*4*	*1*	*10*	*51*	*24*	*9*	*1*	*2*	*103*	*97*	*4*
NON-RESPIRATORY.												
1952 Males	—	1	3	—	2	5	1	1	1	**14**	14	—
1951 Males	—	*3*	*3*	*4*	*4*	—	*4*	*1*	—	*19*	*14*	—
1952 Females	—	1	—	2	5	5	1	2	—	**16**	13	—
1951 Females	*1*	*1*	*1*	*1*	*3*	*2*	*1*	*2*	—	*12*	*7*	—
RESPIRATORY AND NON RESPIRATORY.												
1952 Male and Female	2	10	16	15	78	45	36	50	8	**260**	235	8
1951 Male and Female	*4*	*15*	*9*	*19*	*86*	*50*	*34*	*28*	*12*	*257*	*222*	*10*

The appended graph shows the relative sickness and death rates from respiratory tuberculosis during the past few years. This graph gives the actual number of cases and deaths. As regards the site of the disease, in the 30 cases notified as suffering from tuberculosis other than respiratory, two suffered from tuberculosis of the bones and joints (including spinal tuberculosis), four from tuberculous meningitis, nine from tuberculous glands, nine from genito-urinary disease, one from abdominal tuberculosis, and five from generalised and other forms of tuberculosis.

Of the 230 notified cases of respiratory tuberculosis, 227 were confirmed, and of the 30 non-respiratory cases, 27 were confirmed.

Table B shows the number of persons residing in Aberdeen who, at 31st December, 1952, were known to be suffering from tuberculosis, namely:—1,249 respiratory and 61 non-respiratory cases: a total of 1,310.

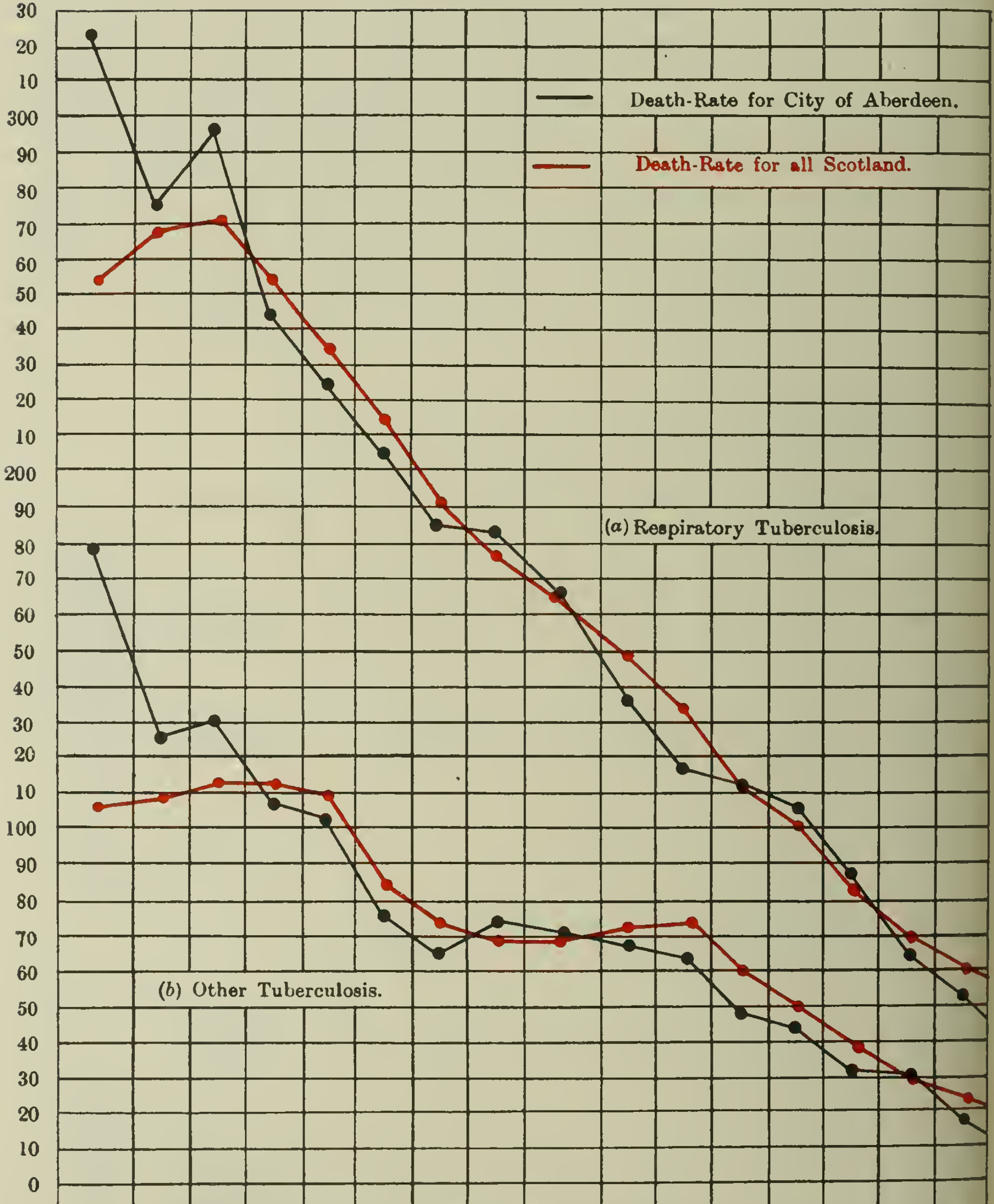
B.—NUMBER OF PERSONS RESIDING IN ABERDEEN AT 31ST DECEMBER, 1952, WHO WERE KNOWN TO BE SUFFERING FROM TUBERCULOSIS.

		NUMBER OF CASES IN AGE-GROUPS.									
		Under 1.	1 and under 5.	5 and under 10.	10 and under 15.	15 and under 25.	25 and under 35.	35 and under 45.	45 and under 65.	65 and upwards.	TOTAL.
RESPIRATORY.											
1. Sputum or other material examined and tubercle bacilli found	Males ...	—	12	22	7	106	176	112	133	13	**581**
	Females	—	7	13	15	164	138	74	34	1	**446**
2. Sputum or other material examined and tubercle bacilli never found	Males ...	—	13	15	8	36	15	6	4	2	**99**
	Females	—	9	10	16	43	18	8	6	1	**111**
3. Sputum or other material not examined ...	Males ...	—	—	2	—	2	1	—	1	—	**6**
	Females	—	1	1	1	2	1	—	—	—	**6**
TOTAL		—	**42**	**63**	**47**	**353**	**349**	**200**	**178**	**17**	**1,249**
NON-RESPIRATORY.											
1. Abdominal...	Males ...	—	—	—	—	—	—	—	—	—	**—**
	Females	—	—	—	1	1	1	—	—	—	**3**
2. Spine	Males ...	—	—	1	1	1	—	—	—	—	**3**
	Females	—	—	1	—	1	3	—	2	—	**7**
3. Bones and joints (exclusive of spine).........	Males ...	—	—	—	—	2	—	1	—	—	**3**
	Females	—	—	—	—	1	—	—	—	—	**1**
4. Superficial glands.........	Males ...	—	—	1	2	—	—	—	—	1	**4**
	Females	—	—	—	—	3	3	—	1	—	**7**
5. Lupus	Males ...	—	—	—	—	—	—	—	—	—	**—**
	Females	—	—	—	—	—	—	—	1	—	**1**
6. Other parts or organs	Males ...	—	3	2	1	3	2	1	—	2	**14**
	Females	—	4	1	3	5	4	—	1	—	**18**
TOTAL		—	**7**	**6**	**8**	**17**	**13**	**2**	**5**	**3**	**61**
RESPIRATORY AND NON-RESPIRATORY TOTAL		—	**49**	**69**	**55**	**370**	**362**	**202**	**183**	**20**	**1,310**

TUBERCULOSIS, 1856-1952—

ALL AGES

Deaths per 100,000 of Population. (Civilian



Yrs.	1856-60	61-65	66-70	71-75	76-80	81-85	86-90	91-95	96-1900	01-05	06-10	11-15	16-20	21-25	26-30	31-35
	(*a*) RESPIRATORY TUBERCULOSIS.															
Abdn.	322	274	298	243	223	204	184	181	167	138	116	111	106	88	62	52
All Scot.	253	266	270	254	234	213	190	175	166	148	131	110	99	81	68	59
	(*b*) OTHER TUBERCULOSIS.															
Abdn	179	128	130	107	101	74	67	72	70	69	61	49	43	31	30	17
All Scot.	104	109	112	111	109	83	71	68	69	70	73	59	48	36	28	21

(Corrected for transferred deaths in 1904 and subsequent years.)

—Quinquennial Periods. to 1950.

Both Sexes.

Population and Civilian Deaths 1940-1946.)

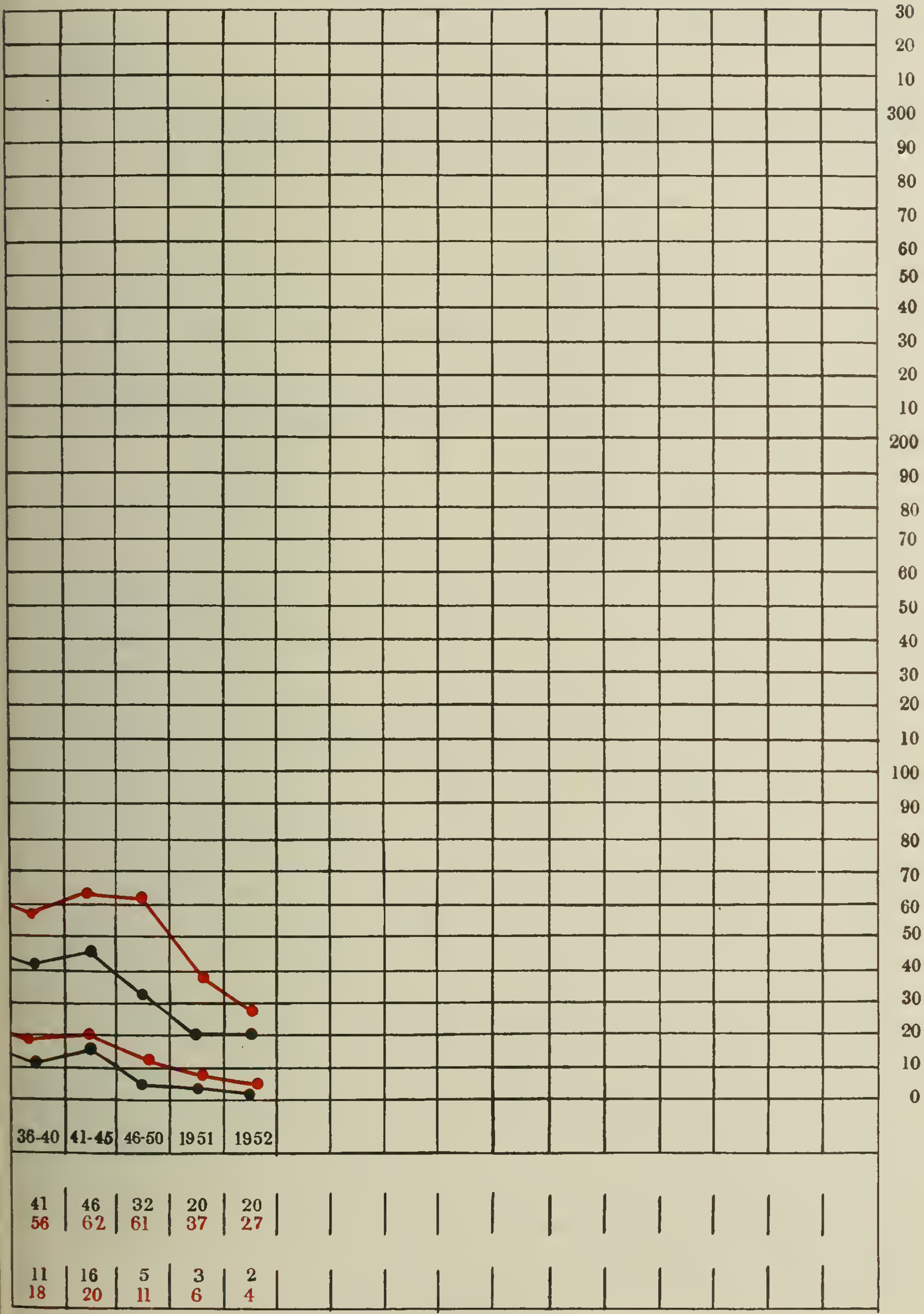


Table C gives particulars of those who died during 1952, detailing the period which elapsed between notification and death and between discharge from institutions and death.

C. NUMBER OF PERSONS WHO DIED FROM TUBERCULOSIS IN ABERDEEN, WITH PARTICULARS AS TO PERIOD ELAPSING BETWEEN NOTIFICATION AND DEATH AND BETWEEN DISCHARGE FROM AN INSTITUTION AND DEATH—YEAR 1952.

	RESPIRATORY.		NON-RESPIRATORY.	
	Males.	Females.	Males.	Females.
	*	*	*	*
Number of Persons who died from Tuberculosis .	28 (25)	8 (11)	2 (1)	2 (4)
of whom—				
Not notified or notified only at or after death .	2 (4)	2 (—)	1 (—)	1 (1)
Notified less than 1 month before death . .	2 (1)	1 (1)	— (1)	1 (1)
,, from 1 to 3 months ,, ,, . .	2 (1)	1 (1)	1 (—)	— (—)
,, ,, 3 to 6 ,, ,, ,, . .	— (1)	— (1)	— (—)	— (—)
,, ,, 6 to 12 ,, ,, ,, . .	2 (4)	— (—)	— (—)	— (1)
,, ,, 1 to 2 years ,, ,, . .	3 (1)	1 (—)	— (—)	— (—)
,, over 2 years	17 (13)	3 (8)	— (—)	— (1)
TOTAL	28 (25)	8 (11)	2 (1)	2 (4)
Number who died within 28 days after discharge from an institution	1 (—)	— (—)	— (—)	— (—)
Number who died more than 28 days after discharge from an institution	8 (4)	2 (2)	— (—)	— (1)

*1951 Figures in brackets.

Here are the total deaths from that disease in recent years:—

	1948.	1949.	1950.	1951.	1952.
Respiratory . .	62	60	38	36	36
Non-Respiratory .	8	6	5	5	4

The death-rates per 1,000 of population from tuberculosis in Scotland and in the four large cities for the years 1952, 1951, and 1950 are given in the following table:—

	1952			1951			1950		
	Total	Resp.	Other	Total	Resp.	Other	Total	Resp.	Other
All Scotland .	**0·32**	0·27	0·04	**0·43**	0·37	0·06	**0·54**	0·47	0·07
Glasgow . .	**0·59**	0·53	0·06	**0·69**	0·60	0·09	**0·95**	0·84	0·11
Edinburgh .	**0·30**	0·26	0·04	**0·37**	0·33	0·04	**0·53**	0·48	0·04
Dundee .	**0·25**	0·22	0·03	**0·43**	0·39	0·04	**0·62**	0·59	0·03
Aberdeen .	**0·22**	0·20	0·02	**0·22**	0·20	0·03	**0·23**	0·20	0·03

The accompanying chart shows the death-rates since 1856, together with a comparison between Aberdeen and all Scotland.

(B) OTHER DISEASES.

Prevention.

Measures for the prevention of diphtheria, whooping cough, and smallpox have already been described in the section dealing with vaccination and immunisation. General measures for the prevention of diseases in children have also been outlined in the section on Maternity and Child Welfare, and health education work generally is outlined in a subsequent section.

It may be appropriate, however, to mention one additional point here, namely, the prevention of accidents. It was felt during the year that the existing knowledge of the causes of home accidents was inadequate and a survey of all accidents occurring in children was begun. Close liaison has been maintained with the hospital staff of the Sick Children's Hospital. Health visitors call periodically at the hospital, obtain such information as is available there about accidents, and thereafter call at the homes of the children to ascertain further particulars. The results of the survey are not so far available but it should provide information of considerable value.

Care and After-Care.

The work of the local health authority has here again been very greatly extended by the National Health Service (Scotland) Act, but, as in so many other fields of the work, shortage of staff has as yet prevented the full implementation of the new duties.

Apart from care and after-care in cases of tuberculosis, it may be relevant to mention here the care services that are being developed for the elderly. District nurses are asked to refer to the Health and Welfare Department any elderly patients whom they have been attending and are ceasing to attend and who, in their opinion, would benefit from visits by health visitors. Similarly, hospital staffs have been asked to refer elderly patients who are being discharged from hospital and who might benefit from such visits. This scheme of after-care for the elderly is still only in process of development but already it is apparent that it will have the double advantage of reducing the need for hospital beds and of keeping active and happy in their own homes many old people who otherwise would become incapable of leading an independent existence.

Chiropody Service.

A report was submitted during the year suggesting that, under Section 27 of the National Health Service (Scotland) Act, 1947, a chiropody service be provided for persons of pensionable age resident in the City who are not engaged in remunerative work and who are certified by their medical practitioners to be in need of foot treatment otherwise than by reason of pathological condition. The Corporation approved of the scheme and the first clinic was held on 24th July, and thereafter three times per week at the Castlegate Maternity and Child Welfare Centre. During the period to 31st December, 165 persons received treatment and 336 visits were paid by those persons. Thirteen cases were treated in their own homes, necessitating 23 visits. Aberdeen, in this as in so many other health matters, has been a pioneer in the provision of services. This service is proving of inestimable benefit to the elderly.

11.—CONTROL OF INFECTIOUS DISEASES.

General.

1952 witnessed a very welcome decline in the incidence of dysentery (from 225 notified cases in 1951 to 14), and cerebro-spinal fever (from 24 cases to 7). There were increases in the numbers of notified cases of acute primary pneumonia (from 242 cases in 1951 to 301 in 1952), poliomyelitis (from 4 cases to 18), and smaller increases in the prevalence of erysipelas, infective jaundice, puerperal fever, puerperal pyrexia, and scarlet fever.

Cerebro-Spinal Fever.

7 cases were notified in 1952, as compared with 24 in 1951, and 14 in 1950. This disease had a very high fatality rate in the past, and it is pleasant to note that, for the third year in succession, there was no death from this cause.

Chickenpox.

During 1952, 48 cases were brought to the knowledge of the department. As this disease is not compulsorily notifiable, the number of cases intimated is no real indication of the prevalence of chickenpox in the City.

Continued Fever (Undulant).

A single case was notified during the year.

Diphtheria.

In 1951 a record was established: for the first time there were no confirmed cases during an entire year. In 1952, 3 cases were notified—2 boys aged 4 years and 14 years, respectively, and 1 woman aged 32 years.

With the exception of 1 death in 1950, in a non-immunised child of seventeen months, there have been no deaths since 1945.

It is interesting to observe the cases and deaths in three-yearly periods:—

	Cases.	Deaths.
1950-1952 . .	5	1
1947-1949 . .	16	0
1944-1946 . .	357	14
1941-1943 . .	859	39

The tremendous year by year reduction from the 372 cases and 19 deaths of 1941 to the figures of to-day bear eloquent witness to the efficacy of diphtheria immunisation (which began on a nation-wide scale in 1941 although employed to a limited extent in Aberdeen before that year). Details about immunisation are recorded elsewhere in this report.

The accompanying chart gives the attack incidence and death-rate from 1882.

Dysentery.

In 1952 there were 14 notified cases of this disease as compared with 225 in 1951, and an annual average of 172 in the decennium 1942-1951. The very large annual fluctuations in the recorded amount of dysentery are not easy to explain.

Encephalitis Lethargia.

No cases were notified during 1952.

Erysipelas.

There were 32 cases of erysipelas in 1952 as compared with an annual average of 68 in the preceding decennium. Despite a slight rise from 1951 to 1952, this disease is becoming less prevalent.

Infective Jaundice.

During the year there were 10 confirmed cases of infective jaundice. Of these, 1 was a fish merchant and 8 were fishworkers. The remaining case, which proved fatal, was a retired person who assisted in the premises of a fish merchant and game dealer.

Leprosy.

This disease was made compulsorily notifiable on 1st September, 1951. No case has been reported in this area.

Malaria.

Two cases were notified in 1952, as compared with 1 in 1951, and 8 in 1950.

Measles.

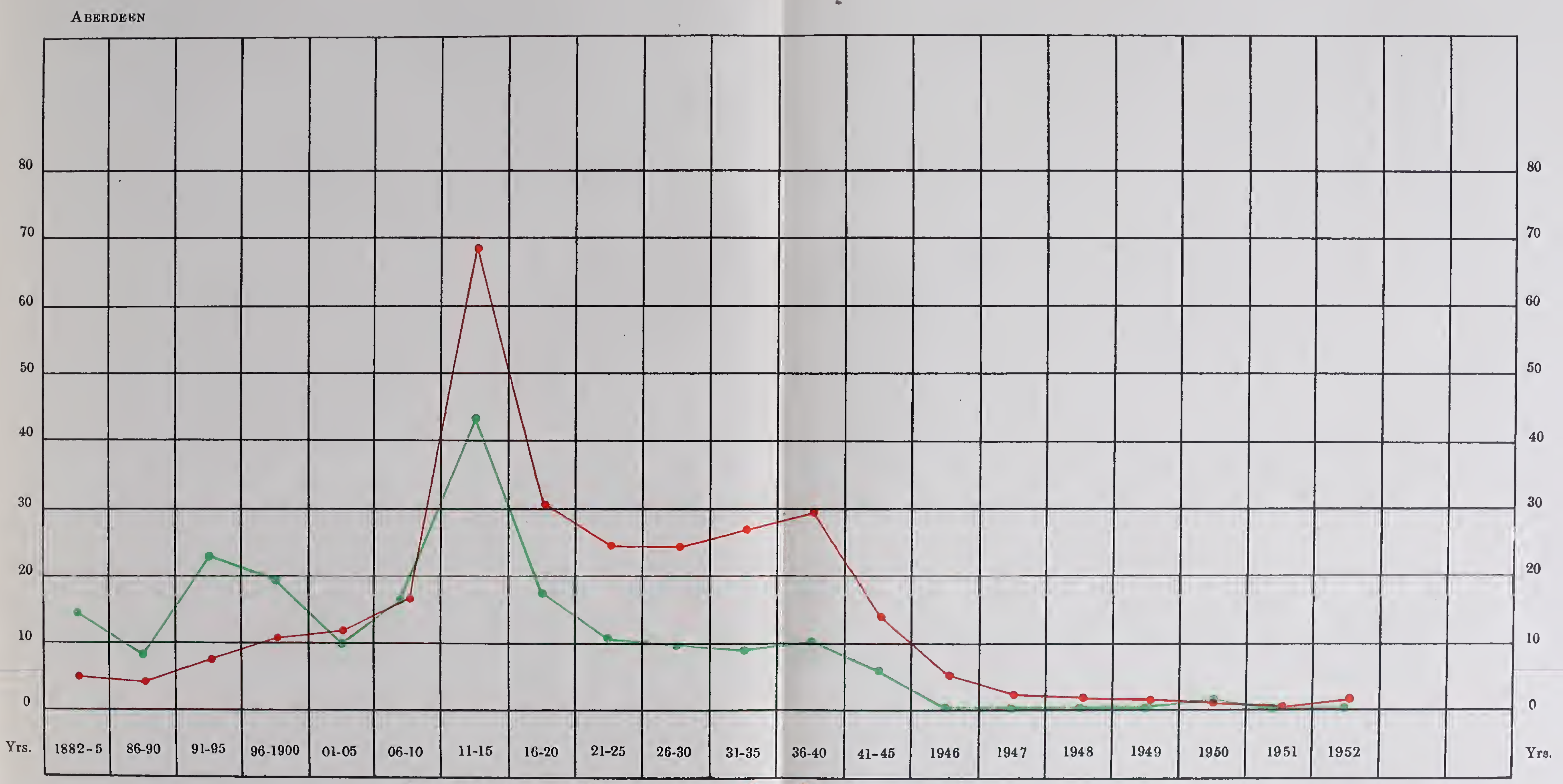
Compulsory notification of this disease in Aberdeen was, after a very short trial, discontinued in 1903 and has not as yet been re-instituted. General practitioners are, however, encouraged to intimate cases to the department. In 1952, 801 cases were voluntarily intimated, and there were no deaths from the disease. The corresponding intimations for 1951 were 824, with one death.

Ophthalmia Neonatorum.

For the third consecutive year no cases were notified. The eradication of this formerly serious cause of blindness constitutes one of the major triumphs of preventive medicine.

Pneumonia, Acute Influenzal.

Of 18 cases of acute influenzal pneumonia notified in 1952, 13 occurred during the months of April and May. There were 5 deaths at 39, 44, 60, 65, and 68 years, respectively. In the preceding year, 10 cases were notified with 2 deaths,



DIPHTHERIA—Attack Incidence per 10,000 of population
Deaths per 100,000 of population
1882 - 1952 : QUINQUENNIAL AVERAGES to 1945.

Pneumonia, Acute Primary.

During 1952, 301 cases were notified, with 13 deaths, as compared with 242 cases and 43 deaths in 1951. During the ten years, 1942-51, the annual average number of cases was 393, and the annual average number of deaths was 45. Of the 301 cases in 1952, 243 or 81 per cent. received institutional treatment.

Reports of medical officers of health in other areas (*e.g.*, London) have suggested that pneumonia is considerably undernotified, especially at ages over 65. It is probable that this is true also of Aberdeen. However, there is no reason to suppose that the fraction notified varies from year to year, so notifications may still be used as an index of relative incidence.

Poliomyelitis (Infantile Paralysis).

Eighteen cases of this disease were notified in 1952. One case proved fatal. In 1951 there were 4 cases and no deaths, and in 1950, 36 cases and 2 deaths.

Of the 18 cases, 11 were reported during the third quarter of the year, and the remaining 7 in the fourth quarter.

An analysis of the cases by age and sex is as follows:—

Cases	Total	Under 1 year	Years 1-2	Years 2-5	Years 5-15	Years 15-25	Years 25-35	Years 35-45
Males	10	1	—	2	5	2	—	—
Females . . .	8	1	—	—	2	3	—	2
Total Cases . . .	18	2	—	2	7	5	—	2
Per cent. of Total . .	100	11·1	—	11·1	38·9	27·8	—	11·1

It is of interest to note the age groups affected in various epidemics, and in the following two tables are given the age incidence and ages at death of cases occurring in 1952, 1950, 1947, and 1944:—

Cases

Year	Total Cases	Under 1 year		1-2 years		2-5 years		5-15 years		15-25 years		25 years and over	
		No.	Per cent. of Total	No.	Per cent. of Total	No.	Per cent. of Total	No.	Per cent. of Total	No.	Per cent of Total	No.	Per cent. of Total
1952	18	2	11·1	—	—	2	11·1	7	38·9	5	27·8	2	11·1
1950	36	1	2·8	7	19·4	12	33·3	8	22·2	3	8·3	5	14·0
1947	48	1	2·1	8	16·7	16	33·3	17	35·4	3	6·2	3	6·2
1944	*20	3	15·0	3	15·0	4	20·0	7	35·0	—	0·0	3	15·0

*Including 5 cases where diagnosis was made in Institutions in Aberdeen but the usual residences were outwith the City.

Deaths.

Year	Total Deaths	Under 1 year	1-2 years	2-5 years	5-15 years	15-25 years	25 years and over
1952	1	—	—	—	—	1	—
1950	2	—	—	—	—	1	1
1947	6	—	1	2	2	—	1
1944	4	1	—	—	*2	—	1

* 2 deaths transferred to usual residences outwith Aberdeen.

Of the 18 cases in 1952, 3 had severe paralysis (including the patient who died), 5 had moderate paralysis, 4 had a slight degree of paralysis, and the others had none.

Puerperal Fever and Puerperal Pyrexia.

Thirty cases of puerperal fever and puerperal pyrexia were notified. Seventeen cases were confirmed as suffering from puerperal fever. No deaths were registered from this cause. The annual average number of cases and deaths in the preceding ten years was 33 and 1 respectively.

Thirteen cases were classified as cases of puerperal pyrexia. In the preceding decennium, the annual average number of these cases was 20.

The 17 cases of puerperal fever and the 13 of puerperal pyrexia all received institutional treatment in the City Hospital.

Scarlet Fever.

In 1952, 314 cases of scarlet fever were notified, as compared with an annual average of 299 in the decennium 1942-1951. There were no deaths for the fourth consecutive year. In recent years this disease has assumed a very mild character.

Smallpox.

Aberdeen has remained free from smallpox since 1930.

Analysis of the vaccinations carried out in 1952 by general practitioners and at child welfare clinics is given in an earlier section of this Report.

Typhoid and Paratyphoid Fevers.

One case of typhoid fever and nine cases of paratyphoid Fever B. were notified in 1952. None of the cases proved fatal.

The solitary sufferer from typhoid fever was a schoolboy of 14 years.

The cases of paratyphoid fever were all reported in the month of May. In one household, 4 members were affected, in another, 3 cases, and the remaining two cases were isolated cases. No connection could be traced between the households, and the limited outbreak remains a mystery.

Whooping Cough.

On 1st January, 1950, this disease became compulsorily notifiable. The number of cases notified during 1952 was 549, as compared with 551 in the preceding year. During 1952 no deaths occurred. In the preceding year there were 3 deaths, all in non-immunised infants.

As indicated elsewhere in this Report, whooping cough immunisation among infants and pre-school children is carried out at the various Child Welfare Centres and at home by general practitioners. During 1952 the number of children so immunised was 1,887.

Infections Generally.

The following tables deal with the various infectious diseases. Table I shows the seasonal variations in the prevalence of each infectious disease, whether compulsorily notifiable or not. In Table II are given the morbidity and mortality from infectious diseases, classified according to age and to the allocation of patients to institutions for purposes of treatment. In Table III the cases and deaths are detailed for each of the years from 1942 to 1952.

Arrangements for Laboratory Services.

The Corporation provided prior to 1948 an up-to-date laboratory at the City Hospital, and, by arrangement with the Regional Hospital Board, the laboratory is still available to the authority. The Public Analyst, who is an employee of the Corporation, works in the laboratory at the City Hospital. The arrangement works satisfactorily.

Table I.—Progress of Infectious Diseases during Twelve Months—Year, 1952.

Disease.		1952.												Whole Year.
		Jan.	Feb.	Mar.	Apr.	May.	June.	July.	Aug.	Sept.	Oct.	Nov.	Dec.	
Cerebro-spinal Fever .	Cases	1	—	—	2	1	1	—	1	—	—	1	—	**7**
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
*Chickenpox .	Cases	6	5	8	4	4	10	3	1	2	2	1	2	**48**
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Continued Fever (Undulant) .	Cases	—	—	—	—	1	—	—	—	—	—	—	—	**1**
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Diphtheria .	Cases	—	—	—	—	—	—	—	—	—	1	2	—	**3**
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Dysentery .	Cases	—	—	—	—	—	1	1	2	—	3	5	2	**14**
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Encephalitis Lethargica .	*Cases*	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Erysipelas .	Cases	4	5	3	2	—	3	1	1	2	—	7	4	**32**
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Jaundice, Acute Infective .	Cases	—	1	2	—	4	—	—	—	1	—	—	2	**10**
	Deaths	—	—	*1*	—	—	—	—	—	—	—	—	—	*1*
Leprosy .	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Malaria . .	Cases	—	1	—	—	—	1	—	—	—	—	—	—	**2**
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
*Measles . .	Cases	9	18	23	7	33	21	20	10	20	138	263	239	**801**
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Ophthalmia Neonatorum	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
Plague . .	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Pneumonia Acute Influenzal .	Cases	1	—	—	8	5	—	—	—	2	1	—	1	**18**
	Deaths	—	—	—	*3*	*2*	—	—	—	—	—	—	—	*5*
Pneumonia, Acute Primary	Cases	28	28	27	35	28	22	11	10	15	20	28	49	**301**
	Deaths	—	*4*	*2*	*1*	*1*	*1*	*1*	—	—	*1*	—	*2*	*13*
Poliomyelitis, Acute . .	Cases	—	—	—	—	—	—	1	2	8	2	4	1	**18**
	Deaths	—	—	—	—	—	—	—	—	—	—	*1*	—	*1*
Puerperal Fever	Cases	2	—	3	2	1	1	—	1	1	3	3	—	**17**
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerperal Pyrexia	Cases	—	1	—	—	1	—	2	3	1	2	1	2	**13**
Scarlet Fever .	Cases	20	18	11	14	13	29	17	13	30	55	56	38	**314**
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Smallpox .	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Tuberculosis, Respiratory .	Cases	19	18	23	13	22	18	11	13	25	18	22	28	**230**
	Deaths	*8*	*4*	*2*	*4*	*1*	*3*	*2*	*1*	*3*	*1*	*3*	*4*	*36*
Tuberculosis, Non-respiratory	Cases	5	1	2	2	4	6	3	2	1	1	2	1	**30**
	Deaths	—	*1*	—	—	—	*2*	*1*	—	—	—	—	—	*4*
Typhoid Fever	Cases	—	—	—	—	—	—	1	—	—	—	—	—	**1**
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Para-Typhoid A. . .	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Para-Typhoid B. . .	Cases	—	—	—	—	9	—	—	—	—	—	—	—	**9**
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Typhus Fever	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Whooping Cough . .	Cases	56	69	85	62	54	39	30	37	26	34	30	27	**549**
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Total .	Cases	151	165	187	151	180	152	101	96	134	280	425	396	**2,418**
	Deaths	*8*	*9*	*5*	*8*	*4*	*6*	*4*	*1*	*3*	*2*	*4*	*6*	*60*
Influenza, excl. Influenzal Pneumonia .	*Deaths*	—	—	—	—	—	—	—	—	—	—	—	—	—

*Not compulsorily notifiable.

TABLE II.—MORBIDITY AND MORTALITY FROM INFECTIOUS DISEASES DURING 1952.

DISEASE		NO. OF CASES AND DEATHS AT VARIOUS AGE-PERIODS								Cases receiving Institutional Treatment	Cases not receiving Institutional Treatment
		At all Ages	YEARS								
			Under 1	1-5	5-15	15-25	25-45	45-65	65+		
Cerebro-spinal Fever	Cases	7	4	1	1	1	—	—	—	7	—
	Deaths	—	—	—	—	—	—	—	—	—	—
*Chicken Pox ...	Cases	48	3	15	28	—	1	—	1	36	12
	Deaths	—	—	—	—	—	—	—	—	—	—
Cholera	Cases	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—
Continued Fever (undulant)	Cases	1	—	—	—	—	1	—	—	—	1
	Deaths	—	—	—	—	—	—	—	—	—	—
Diphtheria	Cases	3	—	1	1	—	1	—	—	3	—
	Deaths	—	—	—	—	—	—	—	—	—	—
Dysentery ...	Cases	14	1	10	3	—	—	—	—	10	4
	Deaths	—	—	—	—	—	—	—	—	—	—
Encephalitis Lethargica...	Cases	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—
Erysipelas	Cases	32	—	—	—	—	8	19	5	13	19
	Deaths	—	—	—	—	—	—	—	—	—	—
Infective Jaundice ...	Cases	10	—	—	—	3	5	2	—	10	—
	Deaths	*1*	—	—	—	—	—	*1*	—	*1*	—
Leprosy	Cases	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—
Malaria	Cases	2	—	—	1	—	1	—	—	2	—
	Deaths	—	—	—	—	—	—	—	—	—	—
*Measles	Cases	801	8	151	635	5	2	—	—	79	722
	Deaths	—	—	—	—	—	—	—	—	—	—
Ophthalmia Neonatorum	Cases	—	—	—	—	—	—	—	—	—	—
Plague	Cases	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—
Pneumonia, Acute Influenzal	Cases	18	—	—	—	1	11	4	2	5	13
	Deaths	*5*	—	—	—	—	*2*	*1*	*2*	*2*	*3*
Pneumonia, Acute Primary	Cases	301	42	32	32	30	57	65	43	243	58
	Deaths	*13*	*4*	*1*	—	—	*1*	*5*	*2*	*11*	*2*
Poliomyelitis, Acute	Cases	18	2	2	7	3	4	—	—	17	1
	Deaths	*1*	—	—	—	*1*	—	—	—	*1*	—
Puerperal Fever	Cases	17	—	—	—	7	10	—	—	17	—
	Deaths	—	—	—	—	—	—	—	—	—	—
Puerperal Pyrexia	Cases	13	—	—	—	7	6	—	—	13	—
Scarlet Fever...	Cases	314	—	104	199	8	1	2	—	79	235
	Deaths	—	—	—	—	—	—	—	—	—	—
Small-pox ...	Cases	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—
Tuberculosis Respiratory	Cases	230	2	8	26	71	69	47	7	208	22
	Deaths	*36*	—	*1*	—	*2*	*7*	*20*	*6*	*22*	*14*
Tuberculosis Non-respiratory	Cases	30	—	2	5	7	12	3	1	27	3
	Deaths	*4*	—	*1*	*1*	*1*	—	*1*	—	*4*	—
Typhoid Fever	Cases	1	—	—	1	—	—	—	—	1	—
	Deaths	—	—	—	—	—	—	—	—	—	—
Paratyphoid A	Cases	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—		—	—	—	—	—	—	—
Paratyphoid B	Cases	9	—	4	1	3	—	1	—	9	—
	Deaths	—	—	—	—	—	—	—	—	—	—
Typhus Fever	Cases	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—
Whooping Cough.........	Cases	549	64	272	207	2	2	2	—	26	523
	Deaths	—	—	—	—	—	—	—	—	—	—
Total ...	Cases	2418	126	602	1147	148	191	145	59	805	1613
	Deaths	*60*	*4*	*3*	*1*	*4*	*10*	*28*	*10*	*41*	*19*

* Not compulsorily notifiable.

TABLE III.—MORBIDITY AND MORTALITY FROM INFECTIOUS DISEASES DURING EACH YEAR FROM 1942 TO 1952.

Disease.		1952	1951	1950	1949	1948	1947	1946	1945	1944	1943	1942	ANNUAL AVERAGE 1942 to 1951.
Cerebro-Spinal Fever . .	Cases	7	24	14	9	5	12	28	25	8	16	20	16·1
	Deaths	0	0	0	1	2	2	0	3	0	8	3	1·9
*Chickenpox .	Cases	48	16	26	23	62	23	60	14	36	44	60	36·4
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0·0
Continued Fever (Undulant) .	Cases	1	0	9	4	1	3	4	1	1	1	9	3·3
	Deaths	0	0	0	0	0	0	0	0	0	0	1	0·1
Diphtheria .	Cases	3	0	2	3	4	9	68	136	153	156	331	86·2
	Deaths	0	0	1	0	0	0	0	9	5	5	15	3·5
Dysentery .	Cases	14	225	67	34	137	13	100	331	83	335	396	172·1
	Deaths	0	1	0	0	1	0	0	3	5	6	10	2·6
Encephalitis Lethargica .	Cases	0	0	1	0	0	0	0	0	0	0	1	0·2
	Deaths	0	0	1	0	0	0	0	0	0	0	1	0·2
Erysipelas .	Cases	32	23	37	48	64	65	104	79	54	90	114	67·8
	Deaths	0	1	0	0	0	0	2	2	0	1	2	0·8
Infective Jaundice	Cases	10	4	10	11	10	6	6	4	4	6	10	7·1
	Deaths	1	2	0	1	3	0	2	0	0	1	0	0·9
Malaria . .	Cases	2	1	8	9	4	9	23	0	0	1	1	5·6
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0·0
*Measles . .	Cases	801	824	26	402	199	527	500	887	245	501	528	463·9
	Deaths	0	1	1	1	1	3	0	3	0	2	4	1·6
Ophth. Neonatorum	Cases	0	0	0	1	3	7	6	3	6	8	7	4·1
Plague . .	Cases	0	0	0	0	0	0	0	0	0	0	0	0·0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0·0
Pneumonia, Acute Influenzal .	Cases	18	10	32	10	7	4	13	3	12	56	1	14·8
	Deaths	5	2	7	4	3	2	7	0	2	27	1	5·5
Pneumonia, Acute Primary .	Cases	301	242	422	443	444	404	379	347	424	447	374	392·6
	Deaths	13	43	58	41	42	53	38	34	40	50	46	44·5
Poliomyelitis, Acute	Cases	18	4	36	3	5	48	1	0	20	1	0	11·8
	Deaths	1	0	2	0	0	6	0	0	2	0	0	1·0
Puerperal Fever	Cases	17	13	35	46	25	42	52	37	24	40	15	32·9
	Deaths	0	1	0	1	0	1	1	2	1	2	5	1·4
Puerperal Pyrexia	Cases	13	10	11	13	34	33	26	4	13	19	41	20·4
Scarlet Fever .	Cases	314	299	513	275	252	205	465	316	202	231	234	299·2
	Deaths	0	0	0	0	1	0	0	0	0	1	0	0·2
Smallpox .	Cases	0	0	0	0	0	0	0	0	0	0	0	0·0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0·0
Tuberculosis, Respiratory .	Cases	230	226	270	222	279	172	190	207	171	173	158	206·8
	Deaths	36	36	38	60	62	65	71	70	77	74	76	62·9
Tuberculosis, Non-Respiratory .	Cases	30	31	31	28	37	53	50	48	63	58	61	46·0
	Deaths	4	5	5	6	8	12	12	15	33	26	31	15·3
Typhoid and Paratyphoid Fevers	Cases	10	4	2	4	30	6	2	7	3	0	3	6·1
	Deaths	0	0	0	0	0	1	0	0	0	0	0	0·1
Typhus Fever .	Cases	0	0	0	0	0	0	0	0	0	0	0	0·0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0·0
Whooping Cough	Cases	549	551	449	58	194	176	151	195	346	165	243	252·8
	Deaths	0	3	0	0	2	5	3	4	2	3	5	2·7
Influenza, excl. Influenzal Pneumonia .	*Deaths*	0	7	6	6	1	0	2	7	5	20	3	5·7

*Not compulsorily notifiable.

12.—MENTAL HEALTH.

I. ADMINISTRATION.

(1) Duties.

The Corporation have no responsibility for institutional care of the mentally sick, but they have responsibility for each of the following aspects:—Prevention of mental disease; ascertainment, care and after-care of mental defectives and mentally ill persons in their own homes; and provision of suitable training and occupation for mental defectives over the age of 16 years and for ineducable defectives under that age.

(2) Committee Responsible.

The responsible Committee is the Health and Welfare Committee, except in the case of educable defectives under guardianship and aged 5 to 16 years. The latter are the responsibility of the Education Committee.

(3) Number and Qualifications of Staff Employed.

(*a*) *Medical Officers.*—The certification of insane persons requires two certificates. In general, the first of these certificates is given by the Medical Officer for Mental Health of the North-Eastern Regional Hospital Board, or, in his absence, by one of two other specialists in mental disease whose services have been made available to general practitioners by arrangement with the Executive Council. The second certificate is usually completed by the general practitioner normally attending the patient.

As indicated above, duties in regard to prevention, ascertainment, supervision, and after-care devolve on the medical officers of the Health and Welfare Department. The Medical Officer of Health and several Assistant Medical Officers possess the post-graduate certificate in mental assessment.

There is also on the establishment a post for an Assistant Medical Officer, primarily for mental health work, but this post, although advertised on various occasions in recent years, has remained unfilled owing to lack of suitable candidates.

(*b*) *Psychiatric Social Worker.*—The Corporation have not appointed any psychiatric social worker. Until the middle of 1952, an arrangement operated whereby a psychiatric social worker employed by the University Department of Mental Health was available for a limited amount of time. When the last holder of that post left in June, the University decided for the present not to replace her. On occasions, a psychiatric social worker from the Regional Hospital Board visits local authority cases by special request.

(*c*) *Other Mental Health Workers.*—As yet, none is employed.

(*d*) *Duly Authorised Officers.*—The Senior Assistant Welfare Officer has been designated authorised officer. His duties as authorised officer are (1) to make arrangements for the detention of persons apparently of unsound mind who have no relatives or friends willing or able to take such action; (2) to ensure that adequate domestic arrangements have been made when it is proposed to discharge insane persons from mental hospitals; (3) on the instructions of the Medical Officer of Health, to take steps to remove, pending the presentation of a petition, a supposed defective who is neglected, cruelly treated, or without visible means of support to a place of safety; and (4) to deal with certain types of mentally handicapped children. The Senior Assistant Welfare Officer is assisted by two Assistant Welfare Officers, who are fully trained and versed in mental health certification procedure, &c.

(*e*) *Occupation Centre Supervisors, &c.*—As yet, none is employed.

(4) Co-ordination.

Close liaison is maintained with the North-Eastern Regional Hospital Board and with the Board of Management for the Mental Hospitals.

On the one hand, where a certified defective is placed under guardianship or is boarded out or liberated on licence from a mental hospital, supervision, although legally a matter for the hospital authorities, is undertaken by members of the Corporation staff. On the other hand, in carrying out duties relating to mental illness and mental deficiency, the medical officers of the Corporation have the valuable co-operation and help of the Regional Hospital Board Medical Officer for Mental Health, of the Professor of Mental Health, and of the Physician Superintendents of Kingseat Mental Hospital and the Aberdeen Royal Mental Hospital. The co-operation is good and is much appreciated on both sides.

(5) Duties delegated to Voluntary Associations.

No duties in relation to mental cases have been delegated to any voluntary associations, all duties being carried out by members of the Health and Welfare Department, with the exception of such duties as are, by mutual arrangement, carried out by officers of the Regional Hospital Board (as mentioned above).

(6) Training of Staff.

No particular arrangements have been made.

II. AMOUNT OF WORK UNDERTAKEN.

1. Under Section 27 of the National Health Service (Scotland) Act.

(*a*) *Measures for Prevention of Mental Illness.*

(i) *Health Education by Health Visitors and by Assistant Medical Officers.*

This forms part of the normal health education work undertaken by the department. As more and more of the physical diseases are conquered, the amount of attention focussed on mental health is being proportionately increased.

(ii) *Attempts to assist families placed in situations of abnormal physical or mental or financial strain.*

To relieve physical strain, home helps are provided, as indicated elsewhere in this report. Again, physical strain on parents is frequently relieved by admission of young children to day or to residential nurseries. Financial strain is again frequently relieved by the same means, the mother being, for a time, enabled to undertake whole-time or part-time work with a view to obtaining sufficient money to permit of the paying off of debts, &c.

The health visitors give a good deal of useful advice and guidance on family budgeting and on general domestic problems, and there is, in addition, a fairly good liaison with the National Assistance Board and with the various voluntary societies.

Not the least important factor in assistance of families in situations of abnormal physical, mental, or financial strain is the existence of a Joint Committee (already mentioned in this report) to deal with measures for the assistance of children who are neglected in their own homes. This Committee, by co-ordinating the efforts of health visitors and school nurses, school welfare officers, the National Society for the Prevention of Cruelty to Children, the National Assistance Board, and so on, as well as of bodies like the Council of Social Service, can very often find a practical means of relieving an intolerable strain on households. In addition, this co-ordinating mechanism makes for economy in that the number of persons concerned with each of these difficult families is kept down to a minimum.

(*b*) *Care and After-care of the Mentally Ill and Mental Defective.*

All patients released on probation from mental institutions and residing within the City or boarded out within the City are visited regularly by the authorised officer or one of the assistant welfare officers and are also medically supervised by a medical officer versed in mental health.

There is a grave lack of institutional accommodation for mentally defective persons who are in need of institutional care and supervision.

2. Under Lunacy Act by Duly Authorised Officer and by Medical Staff.

The work undertaken under the Lunacy Act includes advice and guidance on budgeting and general domestic problems; reference to psychiatric clinic so as to secure early preventive treatment, where necessary; close liaison between general medical practitioners and psychiatric specialists and Welfare Department so as to ensure help of any nature required for mentally sick person; completing and negotiating claims of all types of statutory benefits under the welfare, insurance, and sundry pensions Acts; ensuring adeouate protection for property prior to admission to hospital and throughout any period of hospitalisation so as to allay any anxiety over such personal responsibilities which might otherwise retard the desired early improvement and recovery of patients; ensuring the proper care and supervision of all patients boarded out under guardianship and on probation or licence from mental institutions; and securing the certification of patients in terms of the 9th Schedule of the National Health Service (Scotland) Act, 1947, and the various Lunacy Acts.

13.—WORK UNDER NURSERIES AND CHILD-MINDERS REGULATION ACT.

The Nurseries and Child-Minders Regulation Act, 1948, which came into operation on 30th July, 1948, empowers local authorities to supervise (1) nurseries where children up to school-age are looked after for a day, or for longer periods not exceeding six days, and (ii) persons who, for reward, undertake the care of children under the age of five years for similar periods.

There were no applications for registration during the year.

14.—SCHOOL HEALTH SERVICE.

(Figures in this section of the report relate to the school year ending 31st July, 1952.)

STAFFING.

The story of the school health service during the year continued to be one of struggle against staffing difficulties. The numbers of doctors, dentists, and nurses employed were in each case less than the establishment authorised by the Corporation, but each individual member of staff worked hard to ensure that the shortages did not too greatly impair the health of the children.

An additional dental officer was appointed during the year, bringing the total to four (out of an authorised complement of seven), and in the latter part of the year the Council decided to appoint an audiometrician.

GENERAL STATISTICS.

Number of schools—			
(*a*) Primary—Under Education Authority			37
(*b*) Junior Secondary	Do.	Do.	10
(*c*) Secondary	Do.	Do.	3
(*d*) Nursery	Do.	Do.	4
(*e*) (i) Special Schools			2
(ii) Special Classes in ordinary schools			—
(iii) Nursery Classes			6
(*f*) In receipt of grant from Education Committee and under Medical Inspection			2
Number of children on the registers			28,646
Number of children in average attendance			26,759

SANITARY CONDITION OF SCHOOLS.

Medical officers inspected the sanitary arrangements in schools from time to time, and paid particular attention to the ventilation, cleanliness, and hygienic conditions of classrooms during their regular visits to schools.

ROUTINE MEDICAL EXAMINATION.

General.

Systematic medical overhauls were carried out in the case of children in four prescribed age-groups:—I. Entrants (5-6 years); II. Children aged 9 years; III. Children aged 13 years; and IV. Children aged 16 years. In addition, a quick and less comprehensive survey was made of school entrants as soon as practicable after their initial entry.

Four hundred and forty-seven visits were paid to schools by the medical officers in connection with these inspections. Each inspection also involved a good deal of preparatory work by health visitors—*e.g.*, the weighing, measuring, sight-testing, and hearing-testing of children.

Preliminary Inspection of "Entrants."

At the commencement of each term, all school entrants are rapidly reviewed by the medical officers with a view to the detection of obvious physical defects and verminous conditions. The following are the main details found on inspection:—

Total number inspected	3,013
Dirty heads—Nits	74 or 2·5 per cent.
Vermin	6 or 0·2 per cent.
Squints	151 or 5·0 per cent.
Other diseases	52 or 1·7 per cent.
Number excluded for various infections	8 or 0·3 per cent.
Unsatisfactory footgear	3 or 0·1 per cent.
Unsatisfactory clothing	2 or 0·07 per cent.

The proportion with dirty heads (2·7 per cent.) was significantly less than the 1950-51 figure of 4·2 per cent., and a little below the 1949-50 figure of 3·3 per cent. Other figures showed only slight differences from those of 1951.

Systematic Medical Examination.

Details of the number and percentage of individual children in each age-group found to be suffering from particular defects are given in Table II at the end of this section of the Report. A summary is presented on page 64:—

Nature of Defect.	Number Examined.	Number Defective.	Percentage Defective.
1. Clothing unsatisfactory	8,704	13	·1
2. Footgear unsatisfactory	,,	26	·3
3. Cleanliness—			
(*a*) Head: Nits	,,	61	·7
Vermin	,,	15	·2
(*b*) Body: Dirty	,,	11	·1
Vermin	,,	1	·01
4. Skin—			
(*a*) Head: Ringworm	,,	—	—
Impetigo	,,	52	·6
Other diseases	,,	36	·4
(*b*) Body: Ringworm	,,	1	·01
Impetigo	,,	1	·01
Scabies	,,	1	·01
Other diseases	,,	142	1·6
5. Nutritional State—			
Slightly defective	,,	17	.2
Bad	,,	1	·01
6. Mouth and teeth unhealthy	,,	225	2·6
7. Naso-pharynx—			
(*a*) Nose:			
(i) Obstruction requiring observation	,,	1,044	12·0
(ii) Obstruction requiring operative treatment	,,	47	·5
(iii) Other conditions	,,	8	·09
(*b*) Throat:			
(i) Tonsils requiring observation	,,	1,704	19·6
(ii) Tonsils requiring operative treatment	,,	122	1·4
(c) Glands:			
(i) Requiring observation	,,	463	5·3
(ii) Requiring operative treatment	,,	2	·02
8. Eyes—			
(*a*) External diseases:			
Blepharitis	,,	175	2·0
Conjunctivitis	,,	6	·07
Corneal opacities	,,	—	—
Strabismus	,,	444	5·1
Other diseases	,,	71	·8
(*b*) Visual acuity with/without glasses:			
Fair	5,227	1,068	20·4
Bad	,,	105	2·0
Recommended for refraction	,,	454	8·7

Nature of Defect.	Number Examined.	Number Defective.	Percentage Defective.
9. Ears—			
(*a*) Diseases:			
Otorrhœa	8,704	89	1·0
Other diseases	,,	59	·7
(*b*) Defective hearing:			
Grade I	5,227	12	·2
Grade II*a*	,,	1	·02
Grade II*b*	,,	—	—
Grade III	,,	—	—
10. Speech—			
Defective articulation	8,704	38	·4
Stammering	,,	12	·1
11. Mental and Nervous Condition—			
(*a*) Backward	,,	9	·1
(*b*) Dull	,,	2	·02
(c) Mentally deficient (educable)	,,	—	—
(*d*) Do. (ineducable)	,,	—	—
(*e*) Highly nervous or unstable	,,	31	·4
(*f*) Difficult in behaviour	,,	5	·06
12. Circulatory System—			
(*a*) Organic heart disease:			
(i) Congenital	,,	23	·3
(ii) Acquired	,,	19	·2
(*b*) Functional conditions	,,	79	·9
13. Lungs—			
Chronic bronchitis	,,	4	·05
Suspected tuberculosis	,,	60	·7
Other diseases	,,	321	3·7
14. Deformities—			
(*a*) Congenital	,,	34	·4
(*b*) Acquired (infantile paralysis)	,,	11	·1
(*c*) Acquired (probably rickets)	,,	145	1·7
(*d*) Acquired (other causes)	,,	164	1·9
15. Infectious disease	,,	21	·2
16. Other diseases or defects	,,	991	11·4
17. Classification:			
Group I (2,774)	,,	—	31·9
Group II*a*	5,227	522	10·0
Group II*b*	8,704	101	1·2
Group IIc	5,227	10	2
Group III	8,704	4,322	49·7
Group IV*a*	,,	709	8·1
Group IV*b*	,,	266	3·1
Number notified to parents as suffering from defects	,,	1,016	11·7
Number under observation	,,	4.474	51·4
Number of parents present at inspection (7,152)	,,	—	82·2
Number wearing glasses	,,	741	8·5

Most of these figures show comparatively little variation from year to year, but a few points may be selected for mention on the ground of increase or decrease. The percentage with unsatisfactory clothing and unsatisfactory footgear was 0·14 in each case in 1949-50; in 1950-51 it rose to 0·30 and 0·34, respectively; and in 1951-52 it has fallen to 0·15 in respect of clothing, but has remained high (0·30) in respect of footgear. The proportion of children unsatisfactorily nourished increased from 0·35 per cent. in 1949-50 to 0·48 per cent. in 1950-51, and in 1951-52 has declined to 0·21 per cent.

On the other hand the proportion with unhealthy mouth and teeth rose from 1·1 per cent. in 1949-50 to 2 per cent. in 1950-51, and to 2·6 per cent. in 1951-52, a progressive increase which must be viewed with some alarm. Another appreciable rise was in the number of children with nasal obstruction; it is noteworthy that one child in every twelve examined in 1951-52 suffered from this condition.

Again, the proportion of children with diseases of the lung was just under 3 per cent. in 1949-50, 3·9 per cent. in 1950-51, with 4·4 per cent. in 1951-52. And the number of children with deformities, after falling from 4·8 per cent. in 1949-50 to 3·8 per cent. in 1950-51, rose again to 4·1 per cent in 1951-52. Incidentally, in view of the fact that rickets is a deficiency disease which is easy to prevent, it is a little disappointing to note that every year about 1·7 per cent. of children—or one in every fifty-nine examined—is found to be suffering from deformity due to rickets.

Defective Vision and Squint.

As a result of vision testing in schools, 2,096 children (1,009 boys and 1,087 girls) were examined by eye specialists employed by the North-Eastern Regional Hospital Board. The eye clinic was held at Dispensary Buildings, Guestrow, on Mondays, Tuesdays, Thursdays, and Fridays at 2 p.m. Spectacles were prescribed in all necessary cases.

In addition to the 2,096 school children mentioned above, 97 pre-school children were also examined at the clinic. These figures compare with 1,850 school children and 73 pre-school children in the previous year.

For several years the incidence of squint in school entrants has been abnormally high in Aberdeen, higher than in other towns and higher than it formerly was here. In 1950-51, 6·9 per cent. of all school entrants were afflicted with squint, and in 1951-52 the percentage has risen to 7·22. A special investigation will therefore be carried out during 1953.

Classification on routine examination.

Figures for 1951-52 and percentages for the last three years are given below :—

Classification.	1951-52. No.	1951-52. %	1950-51. %	1949-50. %
I. Free from defects	2,774	31·9	37·5	39·7
*IIA. Defective vision but otherwise free from defects	522	10·0	11·9	13·3
IIB. Mouth and teeth unhealthy but otherwise free from defects	101	1·2	0·8	0·2
*IIC. Combination of IIA and IIB . . .	10	0·2	0·1	0·06
I + II	3,407	43·3	50·3	53·3
III. Children with ailments from which recovery is expected in a few weeks	4,322	49·7	43·9	38·7
IV. Children with more serious defects—				
(*a*) Where cure is considered possible	709	8·1	6·2	9·3
(*b*) Where only improvement is considered possible	266	3·1	3·5	2·9

* Percentage with eye defects refers to children receiving visual tests, *i.e.*, a different total from number having routine medical overhauls. Hence the percentage when added will not come to exactly 100.

Other points on routine examination.

1,016 children (or 11·7 per cent. of those examined) were notified to parents as suffering from defects. This percentage compares with 11·3 in 1950-51 and 11·2 in 1949-50.

4,476 children (or 51·4 per cent. of those examined) were kept under observation as compared with 44·2 per cent. and 43·4 per cent. in the two previous years. The increase in the number of children under observation necessitated additional work by the school nurses in respect of the following up of such children.

The number of parents present at examinations was 7,152 or 82·2 per cent. (as compared with 80·1 per cent. and 80·2 per cent. in the two previous years).

The number of children wearing glasses was 741 or 8·5 per cent. This is a shade lower than the 1950-51 figure of 8·6 per cent. but higher than the 1949-50 figure of 7·5 per cent.

HEIGHTS AND WEIGHTS OF CHILDREN EXAMINED.

The following table gives particulars of the heights and weights of children examined :—

	BOYS				GIRLS			
Age Group (years).	Number Examined.	Average Age.	Average Height in Inches.	Average Weight in Pounds.	Number Examined.	Average Age.	Average Height in Inches.	Average Weight in Pounds.
5—6	1,376	5^3	42·7	42·9	1,291	5^3	42·0	40·8
9—10	1,209	9^4	51·3	63·0	1,114	9^5	51·1	61·4
13—14	1,349	13^5	59·9	93·1	1,251	13^5	59·8	97·7
16—17	172	16^5	68·0	136·3	141	16^6	63·8	123·6

For comparison with previous years, reference should be made to Table V on page 80. It will be noted that, when compared with children of a number of years ago, the children of to-day are taller and heavier in each age-group. The differences between 1951-52 and 1950-51 are, however, very slight and operate in both directions: *e.g.*, boys of 5 years 3 months were a shade taller and heavier than in the previous year, but girls of that age were a shade shorter and lighter.

RE-INSPECTION.

Re-inspection includes the re-examination of children who have had some defect or defects discovered at routine medical examinations during the year and for whom treatment had been advised; it also includes certain children who were placed under observation because it was suspected that they might be suffering from some ailment.

Total number of children re-inspected, 2,781.

	Number Re-examined.	Treatment Completed.	2nd Notice.	Number Improved but kept under Observation.
Dirty heads	49	19	22	8
Defective vision . . .	405	178	85	142
Enlarged tonsils . . .	171	62	78	31
Skin diseases	7	5	2	—
Scabies	1	1	—	—
Other diseases . . .	105	41	57	7
Number under observation .	2,954	1,553	—	1,401
Total . . .	3,692	1,859	244	1,589

It will be observed that it is stated that 2,781 represents the total number of children re-inspected, whereas in the table the number is given as 3,692. The difference is due to the fact that some of the children examined had more than one defect.

OTHER EXAMINATIONS.

(1) *Examination of Vision of Seven-year-old Children.*

During the year, 1,909 children born in 1944 had their vision tested, and 184 were referred to the Eye Clinic for refraction.

(2) *Surprise Visits by the School Medical Officers.*

These are unannounced visits to the schools for the purpose of (*a*) supervision of hygienic conditions; (*b*) the investigation of outbreaks of infectious diseases; (*c*) the study of various influences affecting the physical and mental well-being of the children; and (*d*) the examination of mentally handicapped children. During the year, 242 surprise visits were paid.

(3) *Unannounced Visits by the Health Visitors.*

The health visitors have endeavoured to inspect the children in every school during the year. This has been found possible in all Primary and Junior Secondary Schools.

The figures submitted by the health visitors for the year are as under:—

Total number of children examined or re-examined		64,491
Total number of these children with	live Vermin of the head	197
,, ,, ,, ,, ,, ,,	Nits in hair	2,482
,, ,, ,, ,, ,, ,,	Impetigo	30
,, ,, ,, ,, ,, ,,	Scabies	1
,, ,, ,, ,, ,, ,,	Other diseases	943
,, ,, ,, ,, ,, ,,	Unsatisfactory clothing	313
,, ,, ,, ,, ,, ,,	Unsatisfactory footgear	176

Taking the figures for live vermin and nits of the hair as an index of uncleanliness in the schools, the percentage for live vermin is 0·3, and that for nits, 3·8. During the period under review, parents of the children affected received explicit instructions as to the use of D.D.T. hair emulsion, and appropriate cases who are referred to the City Hospital Cleansing Station are treated by this method. D.D.T. hair emulsion is supplied *gratis* to some families who are not likely to obtain it for themselves. As far as actual pediculosis is concerned, the D.D.T. technique continues to be the most efficacious of all the methods yet tried, but it should be emphasised that D.D.T. has no effect in removing nits from the hair.

In addition to the above, the health visitors examined 7,969 "selected" cases, *e.g.*, children who have previously been found to have some defect of cleanliness. Of these, 152 or 0·2 per cent. were found to have live head vermin, and 1,621 or 20·3 per cent. to have nits of the hair. In the remainder, the condition had been cleared up.

(4) *Home Visitation by the Health Visitors.*

The health visitors paid 2,174 visits to homes to give advice, usually on some aspect of uncleanliness. As a result of their visits, the health visitors reported 346 children as being "slightly improved," 354 as "markedly improved," and 180 as "cured" of the condition.

(5) *Tertowie Residential School.*

During the year, 357 children (173 boys and 184 girls) were inspected previous to departure for a three weeks' period at Tertowie Residential School. Because of the length of absence from Aberdeen, it was necessary to insist on a very strict standard of examination. The children all came from junior secondary schools. Of the 357 children examined, three exclusions from the parties were found to be necessary for medical reasons.

MEDICAL TREATMENT.

A—MINOR AILMENTS, SKIN DISEASES, &c.

(1) *Cuts, Bruises, Sprains, Minor Injuries, &c.*

Cases occurring in schools while any of the medical or nursing staff are in the school are dealt with by them, but many cases are given first-aid treatment by the teaching staff, many of whom have first-aid training. Cases which require further treatment are referred to their own doctor or, if of a serious nature (*e.g.*, fractures), to the Casualty Departments of the General Hospitals. No information is at present available about the number of children in this group who have received treatment otherwise than under the Education Authority's scheme, *i.e.*, by their own medical attendant or at any of the hospitals.

(2) *Attendance (Minor Ailments) Clinics.*

These clinics are held at Powis Junior Secondary School on Thursdays at 9·30 a.m. and at the Child Welfare Centre, Castlegate, on Thursdays at 2 p.m. Children are referred from various sources, such as school welfare officers, health visitors, and head teachers. During the year, 1,604 children were referred, and made 1,819 attendances.

(3) *Diseases of the Ear, Nose, and Throat.*

The ear, nose, and throat clinic is held at Dispensary Buildings, Guestrow, on Fridays at 2 p.m. A health visitor is in attendance daily at 4 p.m. for the purpose of giving treatment where necessary. The attendances during the school year 1951-52 were as follows:—

Number of new cases	89
Number referred to hospital	4
Number referred to own doctor	21
Number treated at clinic	32
Number discharged requiring no treatment	32
Total attendances at clinic	1,138
Number discharged cured	80

About 85 per cent. of the new cases are cases of diseases of the ear alone. The vast majority of cases of enlarged tonsils and adenoids are not referred to the Ear, Nose, and Throat Clinic but are referred to the family doctor in the first instance.

(4) *Diseases of the Eye, excluding defective vision.*

These cases continue to be referred, by arrangement, to the Eye Institution, 142, King Street, Aberdeen. The number of cases so referred was 11 of epidemic conjunctivitis and 16 of severe blepharitis.

(5) *Diseases of the Skin.*

Only 1 case of ringworm of the scalp and 10 cases of ringworm of the body were found and treated, as compared with 3 and 27 respectively in the previous year. All cases of ringworm are referred, by arrangement, for treatment at the Skin Out-Patient Department, Aberdeen Royal Infirmary, Woolmanhill.

With regard to impetigo, 85 children were treated at the School Skin Clinic, Dispensary Buildings, Guestrow, Aberdeen : 627 attendances were involved. (The figures for the previous year were 68 children and 658 attendances).

With regard to scabies, cases are usually referred for treatment to the Cleansing Station at the City Hospital, along with all contacts, adults as well as children. Seventeen families, of whom one or more school-child members of the family were found to be suffering from scabies, were so dealt with, involving a total of 23 adults, 29 school children, and 10 children under school-age. These figures are considerably below the corresponding figures for 1950-51.

The numbers of children known to the department to have been treated for the undernoted skin ailments at the Skin Out-Patient Departments of the hospitals were as follows:—

Acne	4	Neuro-dermatitis	2
Eczema	1	Psoriasis	1
Molluscum-contagiosum	5	Tylosis	1
Nævi	2	Warts	112

Body vermin was found in the case of four families, involving 15 school children and 1 pre-school child.

B—Nose and Throat (Operative Treatment).

Cases requiring operative treatment are referred either to the Royal Aberdeen Hospital for Sick Children or to the City Hospital.

C—Orthopædic and Postural Defects (Specialist Treatment).

The Orthopædic Clinic, inaugurated under the auspices of the Cripples' Welfare Association, and commenced in May, 1942, is now controlled by the North-Eastern Regional Hospital Board. The clinic is held in Charlotte Street at intervals of approximately one month, according to the number of cases to be examined, and conducted by one of the Orphopædic Surgeons of Aberdeen Royal Infirmary. Special remedial exercises for suitable cases are arranged to take place at least once per week at the nearest Junior Secondary School. These classes are conducted by specialist Physical Instructors.

During the year, 112 children were examined by the Orthopædic Surgeons, and of these, 18 were referred to one or other of the General Hospitals for further investigation and treatment in hospital; special remedial exercises were recommended for 7; and no action further than the slight raising of soles and heels of shoes in some cases was considered necessary in the case of 87 children.

In addition to the above-mentioned cases, 110 children who had previously been attended at the clinic paid re-visits for ascertainment of the progress of the prescribed treatment.

D—Speech Defects.

The Education Committee employs three speech therapists working under a superintendent of the speech therapy department. Patients treated during the year included 19 from special schools and 351 from ordinary schools. There is, unfortunately, a large waiting list for speech therapy.

E—Child Guidance.

Owing to shortage of school medical staff, co-operation with the child guidance clinic was not practicable during the year.

DENTAL INSPECTION AND TREATMENT.

(1) *Inspection.*

Thirty-four sessions were devoted to dental inspection of children in schools (as compared with two sessions in 1950-51). At these sessions, 3,536 children were inspected (as compared with 178 in 1950-51). The age distribution of these children was—691 aged 7 years, 561 aged 8, 453 aged 9, 65 aged 12, and 1,766 aged 13.

(2) *Treatment.*

1,415 sessions were devoted to treatment (as compared with 708 in 1950-51).

Of the 3,536 children seen in school, 3,243 (or 92 per cent.) were found to require treatment, and, of these, 2,125 or 65·5 per cent. intimated acceptance of treatment; 107 intimated that their children were being privately treated. Refusals numbered 1,011, this being the number of unsigned cards returned at the time of the dental inspections. During the year, fifty to sixty per cent. of these cases ask for treatment but are then classified as emergency cases.

It is regrettable that the number of children requiring dental treatment continues to rise. The figure of 92 per cent. last year contrasts with 91 per cent. in the previous year, and 65 per cent. in the year before that.

Figures for the number of treatments given are recorded below:—

	Systematic (Routine) Cases.	Special and Emergency Cases.
Number of children actually treated by the school dental officers	1,420	267
Number of attendances made by children for treatment	5,567	2,093
Fillings—		
(*a*) Permanent teeth	3,725	1,267
(*b*) Temporary teeth	113	37
Extractions—		
(*a*) Permanent teeth	440	167
(*b*) Temporary teeth	665	160
Anæsthetics—		
Number of administrations of a general anæsthetic for extractions	185	45
Number of local anæsthetics	374	169
Other operations—		
(*a*) Permanent teeth	1,661	975
(*b*) Temporary teeth	452	33
Orthodontics—		
Number of regulations	12	
Part dentures	16	
Crowns	1	

The following work was performed at the School Dental Clinic in respect of children of pre-school age:—

Number of cases treated	18
Number of visits required	43
Extractions	34
Anæsthetics—	
General	8
Local	7
Fillings	6

DIPHTHERIA IMMUNISATION.

A campaign for immunisation against diphtheria—mainly among the five-year-old "entrants" and the eight-year-old children—was carried out during the summer term. The following figures show the work carried out in the period under review. The figures for the corresponding period for the previous two years are given for comparison—

	1952.	1951.	1950.
Total number of visits paid to the schools	93	86	85
Number of children fully immunised for the first time, (*i.e.*, 2 injections each)—			
(*a*) School children	974	837	793
(*b*) Pre-school children	616	755	471
Number of children who have received a third (or "boosting") injection—			
(*a*) School children	3,685	3,051	3,052
(*b*) Pre-school children	6	3	7

A satisfactory response to the offer of a third injection, mainly to the eight-year-olds, continues to be encouraging; this is a sign that the fear of inoculation, present in the minds of some parents and children in the earlier days of the campaign, has practically passed away.

At the end of June, 1952, a total of 25,387 children of school age was known to have been immunised at some period against diphtheria, *i.e.*, 94·2 per cent. of the children attending Primary and Secondary Schools (including Robert Gordon's College). While this figure looks satisfactory at first glance, it is unsatisfactory that a large—and increasing—number of children should be immunised only after school entry. Ideally all children should receive their primary immunisation long before they are old enough to attend school.

OTHER ACTIVITIES RELATED TO HEALTH OF CHILDREN.

(1) *Linn Moor Convalescent Home, Culter.*

During the year, 70 children (35 boys and 35 girls) were sent to this home.

(2) *School Meals.*

The Director of Education has kindly supplied the following information about the school meals service. In all, there were 18 kitchens, including 5 nursery school kitchens. An average of 190 breakfasts were supplied each day. Two-course lunches were supplied daily to 6,730 pupils. Three-course lunches were supplied to pupils attending the pre-apprenticeship school; the daily average number of such lunches supplied was 110.

(3) *Milk.*

The average number of bottles of pasteurised milk supplied daily was 24,000.

TABLES.

The following tables are appended:—

Table I.	Numbers of children examined in the several age-groups.
Table II.	Return of number and percentage of individual children in each age-group suffering from particular defects.
Table III.	Classification of children examined at systematic medical examinations.
Table IV.	Return of all exceptional children of school age in the area.
Table V.	Average heights and weights—Years 1931-52.

TABLE I.

Total number of children examined at—

(*a*) Systematic examinations—	
Ordinary Schools—	
Entrants	3,477
Second age-group . . .	2,332
Third age-group . . .	2,621
Fourth age-group . . .	—
Secondary Schools—Age-group .	274
	8,704
(*b*) Other examinations—	
Special cases	1,027
Re-inspections by Medical Officers .	2,781
	3,808

Number of individual children inspected at systematic examinations who were notified to parents as requiring treatment (excluding uncleanliness and dental caries):—

Entrants	326
Second age-group . .	309
Third age-group . . .	369
Fourth age-group . . .	—
Secondary age-group . .	12
	1,016

TABLE

SYSTEMATIC

Return of number and percentage of individual children

NATURE OF DEFECT.	Total Examined. All ages.	ENTRANTS.			
		Boys 1,771		Girls 1,706	
1. Clothing unsatisfactory	8,704	2	·1	1	·06
2. Footgear unsatisfactory	,,	3	·2	1	·06
3. Cleanliness—					
(*a*) Head : Nits	,,	5	·3	15	·9
Vermin	,,	—	—	4	·2
(*b*) Body : Dirty	,,	2	·1	1	·06
Vermin	,,	—	—	—	—
4. Skin—					
(*a*) Head :					
Ringworm	,,	—	—	—	—
Impetigo	,,	12	·7	11	·6
Other Diseases	,,	5	·3	9	·5
(*b*) Body :					
Ringworm	,,	—	—	—	—
Impetigo	,,	1	·06	—	—
Scabies	,,	1	·06	—	—
Other Diseases	,,	33	1·9	28	1·6
5. Nutritional state—					
Slightly defective	,,	3	·2	4	·2
Bad	,,	—	—	—	—
6. Mouth and Teeth Unhealthy	,,	30	1·7	36	2·1
7. Naso-Pharynx—					
(*a*) Nose :					
(i) Obstruction requiring observation	,,	251	14·2	182	10·7
(ii) Obstruction requiring Operative Treatment	,,	18	1·0	15	·9
(iii) Other Conditions	,,	1	·06	—	—
(*b*) Throat :					
(i) Tonsils requiring observation	,,	504	28·5	535	31·4
(ii) Tonsils requiring Operative Treatment	,,	49	2·8	39	2·3
(*c*) Glands :					
(i) Requiring observation	,,	151	8·5	140	8·2
(ii) Requiring Operative Treatment	,,	1	·06	—	—
8. Eyes—					
(*a*) External Diseases :					
Blepharitis	,,	25	1·4	26	1·5
Conjunctivitis	,,	2	·1	2	·1
Corneal Opacities	,,	—	—	—	—
Squint	,,	133	7·5	118	6·9
Other Diseases	,,	15	·8	14	·8
(*b*) Visual Acuity (Snellen) :					
Defective—Fair	5,227	—	—	—	—
Bad	,,	—	—	—	—
Recommended for Refraction	,,	60	3·4	64	3·8
Number wearing Glasses	8,704	52	2·9	34	2·0
9. Ears—					
(*a*) Diseases ;					
Otorrhœa	,,	20	1·1	17	1·0
Other Diseases	,,	18	1·0	15	9

II.

EXAMINATIONS.

in each age-group suffering from particular defects.

SECOND AGE-GROUP.				THIRD AGE-GROUP.				FOURTH AGE-GROUP.				ALL AGES.			
Boys 1,194		Girls 1,138		Boys 1,357		Girls 1,264		Boys 172		Girls 102		Boys 4,494		Girls 4,210	
3	·3	4	·4	3	·2	—	—	—	—	—	—	8	·2	5	·1
9	·8	7	·6	3	·2	3	·2	—	—	—	—	15	·3	11	·3
2	·2	20	1·8	—	—	19	1·5	—	—	—	—	7	·2	54	1·3
1	·08	7	·6	1	07	2	·2	—	—	—	—	2	·04	13	·3
3	·3	1	·09	1	·07	3	·2	—	—	—	—	6	·1	5	·1
—	—	1	·09	—	—	—	—	—	—	—	—	—	—	1	·02
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
10	·8	6	·5	6	·4	7	·6	—	—	—	—	28	·6	24	·6
2	·2	4	·4	11	·8	5	·4	—	—	—	—	18	·4	18	·4
—	—	—	—	1	·07	—	—	—	—	—	—	1	·02	—	—
—	—	—	—	—	—	—	—	—	—	—	—	1	·02	—	—
—	—	—	—	—	—	—	—	—	—	—	—	1	·02	—	—
20	1·7	21	1·8	16	1·2	17	1·3	2	1·2	5	4·9	71	1·6	71	1·7
2	·2	4	·4	2	·1	2	·2	—	—	—	—	7	·2	10	·2
—	—	—	—	—	—	1	·08	—	—	—	—	—	—	1	·02
31	2·6	45	4·0	46	3·4	34	2·7	—	—	3	2·9	107	2·4	118	2·8
176	14·7	129	11·3	173	12·7	121	9·6	—	—	12	11·8	600	13·4	444	10·5
4	·3	6	·5	2	·1	2	·2	—	—	—	—	24	·5	23	·5
1	·08	1	·09	1	·07	2	·2	1	·6	1	1·0	4	·09	4	·1
179	15·0	178	15·6	146	10·8	160	12·7	—	—	2	2·0	829	18·4	875	20·8
7	·6	11	1·0	4	·3	12	9	—	—	—	—	60	1·3	62	1·5
57	4·8	46	4·0	38	2·8	28	2·2	1	·6	2	2·0	247	5·5	216	5·1
—	—	—	—	—	—	1	·08	—	—	—	—	1	·02	1	·02
25	2·1	23	2·0	40	2·9	35	2 8	—	—	1	1·0	90	2·0	85	2·0
—	—	—	—	1	·07	1	·0	—	—	—	—	3	·07	3	·07
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
50	4·2	61	5·4	28	2·1	50	4·0	4	2·3	—	—	215	4·8	229	5·4
7	·6	11	1·0	15	1·1	9	·7	—	—	—	—	37	·8	34	·8
243	20·4	210	18·5	263	19·4	292	23·1	32	18·6	28	27·5	538	19·8	530	21·2
21	1·8	23	2·0	27	2·0	34	2·7	—	—	—	—	48	1·8	57	2·3
97	8·1	89	7·8	117	8·6	142	11·2	5	2·9	4	3·9	219	8·0	235	9·4
133	11·1	144	12·7	156	11·5	177	14·0	27	15·7	18	17·6	368	8·2	373	8·9
12	1·0	12	1·1	12	·9	14	1·1	2	1·2	—	—	46	1·0	43	1·0
6	·5	7	·6	7	·5	6	·5	—	—	—	—	31	·7	28	·7

TABLE

SYSTEMATIC

Return of number and percentage of individual children

NATURE OF DEFECT.	Total examined. All ages.	ENTRANTS.			
		Boys **1,771**		Girls **1,706**	
9. Ears—(Continued)—					
(*b*) Defective Hearing :					
Grade I	5,227	5	·3	6	·4
Grade IIA	,,	—	—	—	—
Grade IIB	,,	—	—	—	—
Grade III	,,	—	—	—	—
10. Speech—					
Defective articulation	8,704	18	1·0	8	·5
Stammering	,,	4	·2	1	·06
11. Mental and Nervous Condition—					
(*a*) Backward	,,	3	·2	2	·1
(*b*) Dull	,,	—	—	1	·06
(*c*) Mentally deficient (Educable)	,,	—	—	—	—
(*d*) Mentally deficient (Ineducable)	,,	—	—	—	—
(*e*) Highly nervous or unstable	,,	4	·2	7	·4
(*f*) Difficult in behaviour	,,	2	·1	1	·06
12. Circulatory System—					
(*a*) Organic heart disease :					
(i) Congenital	,,	4	·2	7	·4
(ii) Acquired	,,	1	·06	2	·1
(*b*) Functional conditions	,,	26	1·5	13	·8
13. Lungs—					
Chronic bronchitis	,,	1	·06	2	·1
Suspected tuberculosis	,,	12	·7	11	·6
Other diseases	,,	104	5·9	83	4·9
14. Deformities—					
(*a*) Congenital	,,	6	·3	3	·2
(*b*) Acquired (Infantile paralysis)	,,	6	·3	1	·06
(*c*) Acquired (Probably rickets)	,,	20	1·1	34	2·0
(*d*) Acquired (Other causes)	,,	40	2·3	30	1·8
15. Infectious disease	,,	7	·4	8	·5
16. Other diseases or defects	,,	177	10·0	156	9·1
17. Classification :					
Group I	,,	450	25·4	475	27·8
Group IIA	5,227	—	—	—	—
Group IIB	8,704	5	·3	13	·8
Group IIC	5,227	—	—	—	—
Group III	8,704	1,120	63·2	1,055	61·8
Group IVA	,,	144	8·1	129	7·6
Group IVB	,,	52	2·9	34	2·0
Number Notified to parents	,,	181	10·2	145	8·5
Number under observation	,,	1,141	64·4	1,051	61·6
Number of Parents present	,,	1,714	96·8	1,626	95·3

II (Continued.)

EXAMINATIONS.

in each age-group suffering from particular defects.

SECOND AGE-GROUP.				THIRD AGE-GROUP.				FOURTH AGE-GROUP.				ALL AGES.			
Boys 1,194		Girls 1,138		Boys 1,357		Girls 1,264		Boys 172		Girls 102		Boys 4,494		Girls 4,210	
2	·2	—	—	6	·4	3	·2	1	·6	—	—	9	·3	3	·1
—	—	—	—	1	·07	—	—	—	—	—	—	1	·04	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
8	·7	2	·2	2	·1	—	—	—	—	—	—	28	·6	10	·2
2	·2	—	—	4	·3	1	·08	—	—	—	—	10	·2	2	·05
—	—	—	—	2	·1	2	·2	—	—	—	—	5	·1	4	·1
1	·08	—	—	—	—	—	—	—	—	—	—	1	·02	1	·02
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
9	·8	5	·4	3	·2	2	·2	—	—	1	1·0	16	·4	15	·4
—	—	—	—	1	·07	1	·08	—	—	—	—	3	·07	2	·05
—	—	1	·09	5	·4	5	·4	—	—	1	1·0	9	·2	14	·3
3	·3	2	·2	4	·3	6	·5	1	·6	—	—	9	·2	10	·2
6	·5	13	1·1	9	·7	9	·7	—	—	3	2·9	41	·9	38	·9
—	—	1	·09	—	—	—	—	—	—	—	—	1	·02	3	·07
11	·9	6	·5	7	·5	13	1·0	—	—	—	—	30	·7	30	·7
42	3·5	32	2·8	39	2·9	18	1·4	—	—	3	2·9	185	4·1	136	3·2
7	·6	8	·7	7	·5	3	·2	—	—	—	—	20	·4	14	·3
1	·08	1	·09	1	·07	1	·08	—	—	—	—	8	·2	3	·07
24	2·0	20	1·8	24	1·8	22	1·7	—	—	1	1·0	68	1·5	77	1·8
23	1·9	12	1·1	35	2·6	17	1·3	2	1·2	5	4·9	100	2·2	64	1·5
3	·3	2	·2	—	—	1	·08	—	—	—	—	10	·2	11	·3
146	12·2	152	13·4	153	11·3	184	14·6	4	2·3	19	18·6	480	10·7	511	12·1
380	31·8	378	33·2	500	36 8	431	34·1	123	71·5	37	36·3	1,453	32·3	1,321	31·4
108	9·0	81	7·1	141	10·4	147	11·6	34	19·7	11	10·8	283	10·4	239	9·5
16	1·3	25	2·2	24	1·8	15	1·2	—	—	3	2·9	45	1·0	56	1·3
1	·08	3	·3	5	·4	1	·08	—	—	—	—	6	·2	4	·2
552	46·2	514	45·2	524	38·6	526	41·6	6	3·5	25	24·5	2,202	49·0	2,120	50·4
103	8·6	97	8·5	98	7·2	109	8·6	7	4·1	22	21·6	352	7·8	357	8·5
34	2·8	40	3·5	65	4·8	35	2·8	2	1·2	4	3·9	153	3·4	113	2·7
154	12·9	155	13·6	176	13·0	193	15·3	4	2·3	8	7·8	515	11·5	501	11·9
591	49·5	530	46·6	567	41·8	534	42·2	11	6·4	49	48·0	2,310	51·4	2,164	51·4
1,057	88·5	1,030	90·5	817	60·2	852	67·4	30	17·4	26	25·5	3,618	80·5	3,534	83·9

TABLE III.

SYSTEMATIC MEDICAL EXAMINATIONS.

CLASSIFICATION	ENTRANTS		SECOND AGE-GROUP		THIRD AGE-GROUP		FOURTH AGE-GROUP		TOTAL	
	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the children examined at systematic examinations
I. Children free from defects	925	26·6	758	32·4	931	35·5	160	58·4	**2,774**	**31·9**
II. Children (otherwise free from defects) who suffer from—										
(*a*) Defective vision not worse than 6/12 in the better eye with or without glasses	—	—	189	8·1	288	11·0	45	16·4	**522**	**6·0**
(*b*) Oral Sepsis, etc.	18	0·5	41	1·8	39	1·5	3	1·1	**101**	**1·2**
(*c*) Both (*a*) and (*b*)	—	—	4	0·2	6	0·2	—	—	**10**	**0·1**
Total	18	0·5	234	10·0	333	12·7	48	17·5	**633**	**7·3**
III. Children suffering from ailments (other than those mentioned in II.) from which complete recovery is anticipated within a few weeks	2,175	62·6	1,066	45·5	1,050	40·1	31	11·3	**4,322**	**49·7**
IV. Children suffering from (or suspected to be suffering from) defect less remediable than defects specified in II. or III., distinguishing cases—										
(*a*) Where complete cure or restoration of function (in the case of eye defect, full correction) is considered possible	273	7·9	210	9·0	207	7·9	29	10·6	**709**	**8·1**
(*b*) Where improvement only is considered possible, *e.g.*, without complete restoration of function .	86	2·5	74	3·2	100	3·8	6	2·2	**266**	**3·1**
Total	359	10·3	284	12·1	307	11·7	35	12·8	**975**	**11·2**
Total number of children examined . .	**3,477**	**100%**	**2,342**	**100%**	**2,621**	**100%**	**274**	**100%**	**8,704**	**100%**

TABLE IV.

RETURN OF ALL EXCEPTIONAL CHILDREN OF SCHOOL AGE IN THE AREA.

DISABILITY	At Ordinary Schools	At Special Schools or Classes	At n School or Institution	TOTAL
1. Blind	—	3	1	**4**
2. Partially sighted—				
(*a*) Refractive errors in which the curriculum of an ordinary school would adversely affect the eye condition	—	8	—	**8**
(*b*) Other conditions of the eye, *e.g.*, cataract, ulceration, &c., which render the child unable to read ordinary school books or to see well enough to be taught in an ordinary school	—	2	—	**2**
3. Deaf—				
Grade I	38	—	—	**38**
Grade IIA	1	—	—	**1**
Grade IIB	1	9	—	**10**
Grade III	—	53	—	**53**
4. Defective Speech—				
(*a*) Defects of articulation requiring special educational measures	372	60	—	**432**
(*b*) Stammering requiring special educational measures	238	38	—	**276**
5. Mentally defective children (between 5 and 16 years)—				
(*a*) Educable (I.Q. approx. 50-70)	—	231	—	**231**
(*b*) Ineducable (I.Q. generally less than 50)	—	3	22	**25**
6. Epilepsy—				
(*a*) Mild and occasional	14	5	—	**19**
(*b*) Severe (suitable for care in a residential school)	—	6	—	**6**
7. Physically defective children (between 5 and 16 years)—				
(*a*) Non-pulmonary tuberculosis (excluding cervical glands)	10	2	4	**16**
(*b*) General orthopædic conditions	231	25	—	**256**
(*c*) Organic Heart Disease	90	8	4	**102**
(*d*) Other causes of ill-health	—	10	1	**11**
8. Multiple defects—				
(*a*) Mentally defective and deaf	—	4	—	**4**
(*b*) Physically defective and mentally defective	—	12	—	**12**
(*c*) Mentally defective (ineducable) and blind	—	1	1	**2**

Table V.—Heights and Weights, 1931-1952.

Boys.

Year	GROUP I.—5 Years				GROUP II —9 Years				GROUP III.—13 Years				GROUP IV.—16 Years			
	Average Age		Average Height in Inches	Average Weight in Lbs.	Average Age		Average Height in Inches	Average Weight in Lbs.	Average Age		Average Height in Inches	Average Weight in Lbs.	Average Age		Average Height in Inches	Average Weight in Lbs.
	Yrs.	Mths.			Yrs.	Mths.			Yrs.	Mths.			Yrs.	Mths.		
1931-32	5	3	41·5	40·1	9	0	49·7	58·7	...		...	...	16	1	65·6	127·3
1932-33	5	3	41·6	40·1	9	0	49·6	58·1	...		...	...	16	1	66·2	128·4
1933-34	5	3	41·5	40·3	9	0	49·7	58·6	...		...	...	16	0	65·7	123·9
1934-35	5	3	41·6	40·2	9	0	49·7	58·0	...		...	...	16	1	66·4	128·7
1935-36	5	3	41·9	40·4	9	0	49·9	58·6	...		...	...	16	0	66·2	125·1
1936-37	5	3	41·8	40·4	9	0	50·0	58·8	...		...	...	16	0	65·4	126·7
1937-38	5	3	41·8	40·7	9	0	50·3	59·6	...		...	...	16	0	66·7	129·6
1938-39	5	3	42·0	41·0	9	6	51·3	60·9	13	6	58·6	90·9	16	5	67·7	135·0
1939-40	5	4	42·3	41·6	9	6	50·9	61·3	13	6	58·5	89·8	16	6	67·0	134·1
1940-41	5	3	41·9	41·3	9	4	50·7	60·8	13	5	58·4	88·2	16	4	67·1	132·0
1941-42	5	4	42·0	41·4	9	4	50·8	61·1	13	4	58·3	88·3	16	5	67·4	133·2
1942-43	5	3	42·0	41·2	9	4	50·8	60·8	13	4	58·5	88·8	16	5	67·5	134·0
1943-44	5	3	42·0	41·8	9	5	50·9	62·0	13	5	58·6	89·4	16	7	67·4	134·7
1944-45	5	3	42·2	42·0	9	4	51·0	61·8	13	4	58·4	89·4	16	4	67·5	133·5
1945-46	5	3	42·4	42·1	9	5	51·0	62·2	13	5	58·7	90·1	16	6	67·5	134·3
1946-47	5	2	42·3	41·7	9	2	51·1	62·0	13	5	58·7	90·4	16	6	67·6	130·0
1947-48	5	2	42·3	41·8	9	5	51·1	62·4	13	4	58·7	90·6	16	6	67·5	134·5
1948-49	5	3	42·4	42·4	9	5	51·3	63·3	13	5	58·8	91·4	16	6	67·7	134·3
1949-50	5	3	42·8	42·8	9	5	51·6	63·6	13	5	59·0	91·6	16	6	67·6	135·3
1950-51	5	3	42·5	42·8	9	3	51·5	63·1	13	5	59·1	92·5	16	5	67·4	133·3
1951-52	5	3	42·7	42·9	9	4	51·3	63·0	13	5	59·9	93·1	16	5	68·0	136·3

Girls.

Year	GROUP I.—5 YEARS				GROUP II.—9 YEARS				GROUP III.—13 YEARS				GROUP IV.—16 YEARS			
	Average Age		Average Height in Inches	Average Weight in Lbs.	Average Age		Average Height in Inches	Average Weight in Lbs.	Average Age		Average Height in Inches	Average Weight in Lbs.	Average Age		Average Height in Inches	Average Weight in Lbs.
	Yrs.	Mths.			Yrs.	Mtns.			Yrs.	Mths.			Yrs.	Mths.		
1931-32	5	3	41·0	38·3	9	0	49·1	55·4	...		...	...	16	1	62·3	116·1
1932-33	5	3	41·2	38·5	9	1	49·2	55·9	...		...	...	16	1	63·0	119·0
1933-34	5	3	41·2	38·8	9	0	49·7	56·6	...		...	...	16	1	62·7	115·4
1934-35	5	3	41·4	38·9	9	0	49·6	55·9	...		...	...	16	0	63·1	118·8
1935-36	5	3	41·3	38·5	9	0	49·6	55·9	..		...	...	16	0	63·6	118·8
1936-37	5	3	41·4	38·7	9	0	49·6	56·1	...		...	...	16	0	63·1	119·2
1937-38	5	3	41·7	39·1	9	0	50·1	56·8	...		...	...	16	0	63·8	120·7
1938-39	5	3	41·7	39·3	9	7	51·1	60·5	13	6	59·6	94·4	16	4	63·6	120·2
1939-40	5	4	41·9	40 0	9	6	50·4	59·3	13	5	58·9	92·7	..		...	...
1940-41	5	3	41·7	39·7	9	4	50·2	58·5	13	5	59·0	91·6	16	6	63·6	120·5
1941-42	5	3	41·6	39·8	9	4	50·3	58·6	13	4	58·8	92·0	16	5	64·0	122·3
1942-43	5	3	41·8	40·0	9	4	50·4	58·2	13	4	59·3	92·2	16	6	63·9	120·6
1943-44	5	3	41·6	39·9	9	5	50·4	59·4	13	5	59·3	93·4	16	7	64·4	124·8
1944-45	5	3	41·9	40·1	9	5	50·3	60·5	13	5	59·3	93·4	16	6	63·6	123·8
1945-46	5	3	41·7	40·3	9	6	50·6	60·4	13	5	59·4	94·9	16	6	63·1	121·7
1946-47	5	2	42·7	40·2	9	5	50·7	60·3	13	4	59·3	92·6	16	6	64·2	124·2
1947-48	5	2	42·0	41·2	9	5	50·8	60·6	13	5	59·4	94·8	16	5	63·8	123·2
1948-49	5	3	42·4	41·1	9	5	50·9	61·5	13	5	59·6	96·5	16	5	64·0	123·9
1949-50	5	3	42·1	40·7	9	5	51·0	61·3	13	6	59·6	95·9	16	6	63·9	120·9
1950-51	5	3	42·1	41·0	9	5	51·4	61·1	13	4	59·5	96·1	16	6	63·9	120·3
1951-52	5	3	42 0	40·8	9	5	51·1	61·4	13	5	59·8	97·7	16	6	63·8	123·6

15.—PORT HEALTH ADMINISTRATION.

The Medical Officer of Health is also Port Medical Officer, with control of port health work and port sanitary work. A considerable portion of this work (*e.g.*, inspection of fish, fish premises, and boats) is carried out by the staff of the Sanitary Section. Indeed, a District Sanitary Inspector is normally employed full time on duties in connection with fish. A review of the work carried out by the sanitary inspectors will be given in the Annual Report of the Chief Sanitary Inspector.

During the year the Port Sanitary Regulations of 1933 and 1945 were revoked, and the Public Health (Ships) (Scotland) Regulations of 1952 came into operation on 1st September. These regulations deal with measures to be taken by masters of vessels approaching ports if there is on board a suspected case of infectious disease or if the vessel has come from an infected port, and they also deal with the action to be taken by the Port Medical Officer in such circumstances. Under the old regulations (during the first two-thirds of the year) and the new regulations (during the final third), the usual declarations of health were received, and medical examinations were conducted in cases where they were deemed necessary. No particular difficulties were encountered, and no points call for special mention here.

16.—FOOD SUPPLY AND FOOD HYGIENE.

In the 92 years that have elapsed since the passing of the first Food and Drugs Act, the control of food supplies by officers of local health authorities has gradually changed its direction. Although one occasionally hears of water being added to milk or of cream being skimmed off, the gross adulterations of the past have now become rarities. Similarly, the more obviously unhygienic conditions of food production—the rat-infested, insanitary, underground bakehouse, for example—have to a considerable extent disappeared. In the examination of food samples, the bacteriologist is beginning to play a more important part than the biochemist, and in advice on food hygiene it has become imperative that the medical officer take an active part instead of delegating this subject entirely to the sanitary inspector.

In the past, however, most of the work in connection with *milk*, *ice-cream*, &c., has been undertaken by members of the sanitary section. It will, therefore, be appropriate to omit further mention of these matters here and simply to indicate that the administration of the Acts, Orders, and Bye-laws relating to milk, the details of the milk samples examined during the year, and the administration of the Ice-Cream (Scotland) Regulations, 1948, will be outlined in the Annual Report of the Chief Sanitary Inspector. His report will also contain information about *food premises* inspected, defects found and remedied, and assessment of hygienic standards attained.

Mention may be made here of some points in connection with *meat and other foods*. Of the four private slaughter-houses licensed within the Burgh, two belong to the Flesher Incorporation. The only slaughter-house in operation during the whole of 1952 was Hutcheon Street slaughter-house, which belongs to the above-mentioned Incorporation, as does the Charles Street slaughter-house, which was opened intermittently throughout the year.

The following is a summary of the animals slaughtered and the results of the inspection of the carcases:—

Class of Animal	Total Slaughtered.	Carcases Totally Condemned.	Carcases Partially Condemned.	Weight (in lbs.) of Condemned Meat and Offal.
Cattle	33,082	394	408	301,736
Sheep	171,316	224	219	49,172
Pigs	2,576	106	118	31,806
Calves	3,158	147	1	9,756
	210,132	871	746	392,470

In addition, 606 lots of organs or offal were condemned, and these weighed 171,631 lbs. The total weight of condemned meat and offal thus amounted to 564,101 lbs.

During 1952 there were no prosecutions under the Slaughter of Animals (Scotland) Act, 1928. Some forty-nine licences were issued for the use of the mechanically operated instrument for the slaughter of animals.

The routine work necessary under the various Acts and Orders relating to *Diseases of Animals* was duly carried out. During 1952 there was one outbreak of swine fever.

No particular *food hygiene* campaigns were undertaken in 1952, and no special action was taken in respect of *general nutrition*; but all members of the staff of the Health and Welfare Department—doctors, health visitors, sanitary inspectors, &c.—exerted an educative influence on the public.

17.—SERVICES UNDER NATIONAL ASSISTANCE ACT, &c.

General.

When the National Health Service (Scotland) Act, 1947, and the National Assistance Act, 1948, came into operation, the Corporation decided to combine the former Health Committee and Welfare Committee and to appoint the Medical Officer of Health as principal officer of a combined Health and Welfare Department. This decision made it unnecessary to seek to define in borderline cases the exact demarcation between after-care and rehabilitation; made it unlikely that a patient would be neglected while two departments argued about responsibility; made it improbable that patients would be subjected to the annoyance of visits by members of two separate departments; made it certain that advice on aspects of health and hygiene would be readily available to persons receiving welfare services; made such advice available in respect of buildings (*e.g.*, residential hostels); and—by avoiding duplication of records and of visits—allowed a better service to be given at a lower cost to the community.

Provision of accommodation for elderly, &c.

Under Section 21 of the National Assistance Act, 1948, local authorities are required to provide residential accommodation for aged and infirm persons who cannot adequately look after themselves but who do not require the skilled medical treatment or continuous nursing care available in a hospital. The whole conception of the type of accommodation required for such persons has completely changed; the bleak discomfort of the poor-law institution is gradually being replaced by modern accommodation in homes which are comfortably furnished and conducted with a minimum of rules and which accommodate about 25-40 persons in each home. The aim is to make these old people comfortable, to rehabilitate them where possible, to make them look upon the home as their own home in the truest sense of the word and to keep them interested and active members of the community. (The further and even more important point of trying to keep the majority of old people so healthy that they do not require institutional accommodation is considered elsewhere.)

When the Act came into operation, the only accommodation for the aged and infirm belonging to the Corporation was at Woodend Home. This (being unsuitable for active persons but capable of adaptation for hospital use) was sold to the Regional Hospital Board in 1951, although one of the conditions of sale was that a portion of the accommodation would remain available for aged and infirm persons for a period of seven years.

Since 1948, the Corporation have acquired two buildings and adapted them as homes: Balnagask House (accommodating 22 old persons) was opened in December, 1950, and 3, Ferryhill Place (accommodating 12 persons) was opened in November, 1951. During 1952, although every endeavour has been made to acquire additional homes, the Corporation have only been successful in acquiring 5, Ferryhill Place, and this, in conjunction with 3, Ferryhill Place, will be run as one home and will have accommodation for a total of about 24 persons. In addition, a home for the aged and infirm is in course of erection at Northfield. This home, when completed, will be the first residential hostel for old people specifically erected by a Scottish local authority in conformity with the Act. Two of the main features of this home will be the number of single bedrooms and the number of bedrooms on the ground floor. These will ensure an adequate measure of privacy for the residents and also that only the more active of the residents require to climb stairs.

At the end of 1952, the accommodation already available was, therefore, 34 places, with a further 48 places in process of being made available. This total unfortunately, comprises less than one-third of the accommodation ultimately required.

In addition, the Corporation has entered into an agreement with the Aberdeen Old People's Welfare Council, a voluntary body which has acquired four large houses for the reception of aged persons. By this agreement, the Corporation pay for the maintenance in these homes of Aberdeen persons who are financially unable to meet the charges personally. Similar arrangements have been made with the owners of the King Street Home for Girls, St. Margaret's Hostel, and with the Church of Scotland Committee on Social Service; these bodies receive into their homes certain aged and infirm persons who require accommodation which the Corporation cannot themselves provide, and the Corporation bears such proportion of the cost of maintenance as the persons are not able to meet.

At 31st December, 1952, the number of aged and infirm in residential accommodation (whether belonging to the Local Authority or to voluntary organisations) in respect of whom the Corporation make a contribution towards the cost of maintenance was as follows:—

	Male.	Female.	Total.
Local Authority Homes—			
Balnagask	11	10	21
3, Ferryhill Place	10	—	10
Glenburn Wing of Woodend Hospital . .	79	46	125
Voluntary Homes in Aberdeen—			
Aberdeen Old People's Welfare Council .	16	17	33
St. Margaret's Hostel	—	14	14
King Street Home for Girls	—	7	7
Church Homes	6	4	10
Homes in other Areas	4	—	4
	126	98	224

The Corporation have decided, as a matter of policy, that, when the additional extension to Pitfodels Residential Nursery is completed, the staff at present housed at Thorngrove will be transferred to Pitfodels, and Thorngrove will be adapted as an old people's home. This addition and the erection of the home at Northfield will ease the present demand on accommodation, but the need is still very grave; attempts will have to be made to secure or to erect other suitable buildings.

Medical Supervision in residential accommodation.

Assistant medical officers from the Health and Welfare Department pay periodic visits to the Corporation Homes to supervise the hygienic aspects of each home and to give advice about diet, heating, ventilation, and so on. All the residents have a free choice of private doctor, and receive personal medical care in the same way as do any other member of the community. This system works satisfactorily.

During the year it has been necessary, owing to the deterioration in the condition of one or two residents, to have them transferred to the chronic sick wards of one of the hospitals. This has, so far, not caused any major difficulty but, with the acute shortage of beds for chronic sick, some difficulty may arise in the future. However, it is hoped that, should any such difficulty be encountered, it could be overcome by a suitable two-way arrangement, whereby convalescent persons would be transferred from hospital to hostel and sick patients from hostel to hospital.

Holiday arrangements for persons in homes.

As in the previous years, the Corporation made arrangements for holidays for some of the residents in the Homes; during the summer season, an exchange arrangement was made with four residents from each of the following Homes:—Craigie House, Dundee (Dundee Corporation); Bertha Home, Perth (Perth Town Council; and Preasmor, Aboyne (Aberdeen County Council). These holidays were much appreciated, and it is hoped that they can be continued in 1953.

Cottages for the elderly.

The Town Council have provided houses consisting of one room and a bedroom annexe together with bathroom for elderly couples. These houses have been erected at the following places:—Kaimhill (20) and Northfield (50).

Provision for elderly.

To keep elderly persons fit and healthy in their own homes is a task even more important than the provision of special hostels. It may be convenient to summarise here some provisions made by the Corporation for the health and welfare of the elderly in their own homes:—

(1) Prevention of Illness, Care and After-care.—Visitation of the elderly to ensure that they are in fact receiving, where needed, the services available to them (*e.g.*, meals on wheels, a service towards which the Corporation make a substantial contribution) and to advise them on matters of health and hygiene. These visits are already proving particularly valuable, and the unification of the Health and Welfare Departments is most helpful in that the health visitor (the person on whom rests the statutory duty of advising the whole family on many health matters) can bring her expert knowledge and experience to bear on the problems of the elderly individual.

(2) Home-Help Service.—This service is described elsewhere, but it may be noted that an appreciable proportion of this service is devoted to helping old people, usually for two or three mornings per week. During 1952, 225 persons over 65 years of age received such assistance.

(3) Home Nursing Service.—This is described elsewhere, but 59 per cent. of the district nurses on the day service and 78 per cent. of the time of the nurses on the night service was devoted to persons of pensionable age.

(4) Chiropody Service.—This service is discussed in the section on care and after-care.

(5) Meals-on-wheels Service.—This service is run by the W.V.S. and subsidised by the Corporation. During the year the Corporation paid £123 for 3,690 meals supplied.

WELFARE SERVICES (Section 29).

(*a*) *Cripples and other handicapped persons.*

Under the National Assistance Act, the Corporation have very definite responsibilities for the welfare and training of cripples. By the end of 1952 an administrative scheme had been drafted setting forth certain means by which these responsibilities could be discharged. This scheme will be submitted to the Corporation early in 1953.

(*b*) *Blind Persons.*

A clinic for the examination and ascertainment of blind persons is held each month at Woolmanhill, and is staffed by two consultants employed by the North-Eastern Regional Hospital Board and by a health visitor employed by the Corporation. The Corporation carry out their responsibility for the blind under the Act through the agency of the Royal Aberdeen Asylum for the Blind, who provide training and employment in their workshops in Aberdeen, and the Aberdeen Association for the teaching of the Blind in their Homes, who employ home teachers for the training of the blind and provide certain welfare services. In addition, the Corporation utilise the services provided by certain other voluntary organisations. The following is a summary of the organisations and the payments made to them:—

> *Royal Aberdeen Asylum for the Blind.*—For the financial year ended 31st March, 1952, the Corporation paid to the Royal Aberdeen Asylum for the Blind the sum of £142 16s. in respect of each City worker registered under the Disabled Persons (Employment) Act, 1944. There were 50 workers employed, and the total cost to the Corporation was £7,140; of this sum a grant at the rate of £80 per annum for each worker was recovered from the Ministry of Labour and National Service, making the net expenditure to the Corporation £3,140.
>
> *Aberdeen Association for Teaching the Blind in their Homes.*—The sum of £2 5s. per annum is paid in respect of each certified blind person from Aberdeen on their roll. In addition, a grant of £20 per annum is made to the Association in respect of home workers who are assisted financially by the Association. At the end of the last financial year there were 236 certified blind persons on the roll, including 4 home workers, and the sum of £611 was paid by the Corporation to the Association.

Royal Blind Asylum, Edinburgh.—Two home workers are employed in Aberdeen but are attached to the Edinburgh Home Workers' Scheme, and grant at the rate of £30 per annum for each of them is paid to the Royal Blind Asylum, Edinburgh.

Thomas Burns Homes, Edinburgh.—Two persons belonging to the City of Aberdeen reside in the Homes and are maintained by the Corporation. The net cost of maintenance for the two inmates during the year was £98 16s.

Book Production Grant.—£11 10s. 6d. per year.

Donation to the National Library for the Blind.—£28 per year.

Holiday Home of the Edinburgh Society for the Blind, Ceres, Fife.—Two males and one female sent from this area during 1952.

The number of blind persons on the Register of the Blind as at 31st December, 1952, was 330. The numbers according to the different age-groups are as follows:—

0-2		3-4		5-15		16-17		18-29		30-39		40-49		50-69		70+		TOTAL		
M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	T.
1	—	1	—	4	2	—	—	5	5	19	8	12	26	61	60	47	79	150	180	330

During 1952, 42 persons were examined for the first time, 23 at the Blind Persons' Clinic and 19 at their homes. Re-examination was made of 16 persons. The total number of persons examined was 58, as compared with 55 in 1951.

Of the 42 persons examined for the first time, 35 (or 83 per cent.) were certified blind within the meaning of the Blind Persons Act.

The following statement gives the number of blind persons of 16 years and upwards who were in employment at 31st December, 1952:—

	Males.	Females.
(*a*) In Institutions for the Blind—		
Undergoing industrial training	5	3
Undergoing secondary or professional education	—	—
In workshops	41	10
(*b*) Outwith Institutions for the Blind	12*	1

*Including 6 home workers.

(*c*) *Deaf and Dumb Persons.*

Under the National Assistance Act, 1948, the Corporation are empowered to make provision for the training of deaf and dumb persons and also for their welfare. At the end of the year a scheme embodying certain proposals was in process of being drafted, and it is hoped that it will be submitted to the Corporation early in 1953. As a temporary measure, a payment of £2 5s. per annum is made to the Aberdeen Deaf and Dumb Benevolent Society in respect of each deaf and dumb person on their roll. This Society provides certain welfare services.

(*d*) *Provision of temporary accommodation for persons in urgent need.*

During the year temporary accommodation was provided for 36 persons in urgent need arising in circumstances which could not reasonably have been foreseen. In addition, 135 other persons were guided to suitable accommodation.

(*e*) *Registration and Inspection of Homes for Disabled or Old People's Homes.*

Under the National Assistance Act, no person may open a home for the disabled and old persons without the home being registered by the appropriate local authority. During the year there were no further applications for registration, and the total number of Homes registered in the City is 8.

(*f*) *Section 48—Care and protection of property of persons admitted to hospital or to local authority or voluntary hostels.*

Care, protection, and storage was provided in 268 cases, in addition to handling, at the request of patients or responsible relatives, their varied contractual obligations while they were under care. This service performs a useful function by allaying distress and anxiety which otherwise would retard the recovery of patients.

(*g*) *Section 50—Burial or Cremation of the Dead.*

During the year, 35 persons—28 men and 7 women—were dealt with under this Section.

(*h*) *Reception Centre—Sections 17 (2) and 25 (1) (2), National Assistance Act, 1948.*

At the request of the National Assistance Board, a Reception Centre is provided at the "Gate House," Woodend General Hospital, to meet the needs of persons without a settled way of living. During the year, accommodation was provided for males on 1,833 occasions, for females on 40 occasions, and for dependants on 28 occasions. The total of 1,901 occasions represents an average usage of 5·2 persons per night.

(*i*) *Removal of person by Sheriff's Order.*

Occasionally, persons are in need of care and protection in their own interests or in that of others but cannot be persuaded to enter a hospital or a residential institution. For such persons, it is possible to secure compulsory removal under Section 47 of the Act. This provision is a real necessity which must be interpreted with the utmost discretion and humanity, its provisions being utilised only after all powers of peaceful persuasion have failed. Dealing with such cases entails lengthy and patient visitation by experienced officers over a period of time in an endeavour to secure the peaceful co-operation of the person in need. The success of this mode of approach will be appreciated from the fact that, since 1948, the powers of this section have had to be invoked on only one occasion, and during the past twelve months peaceful persuasion achieved the acceptance of care and supervision in 13 cases where the need was really pressing. Such need frequently occurs in cases of persons advanced in years and living alone, whose normal instincts for cleanliness, respectability, and order have become dulled by senility and advancing physical frailty.

WORK UNDER NURSING HOMES REGISTRATION ACT.

No applications were made to the local authority during the year.

18.—GENERAL SANITATION.

Most sanitary matters will be discussed in the annual report of the Chief Sanitary Inspector, but two points may be selected for mention here.

Water Supplies.

There is an ample supply of water for the City of Aberdeen, obtained from the upper reaches of the River Dee. The water is filtered and chlorinated. Samples of water are taken regularly from the Dee at Braemar, from intake at Cairnton, from filters at Invercannie, and from taps in the City. These samples are tested bacteriologically and biochemically. The results from all samples taken during the year were satisfactory.

River Pollution.

Pollution of the River Don from outside the City is causing anxiety, and has been the subject of special reports. The degree of pollution is such as to be highly objectionable, but it seems probable that no adequate remedial measures will be undertaken until a special Rivers Pollution Board is set up.

19.—HEALTH EDUCATION.

It is perhaps appropriate that health education should be discussed at the end of this report, since the end is always regarded as a place of honour.

To some people who are aware of the Health Weeks, Health Sundays, Health Exhibitions, cinema shows, and so forth of certain other cities, it may seem that Aberdeen's efforts in the field of health education are lame and halting. From that view the writer must emphatically dissociate himself. Certainly more health education is required, and probably no form of human activity is likely to pay richer dividends in the shape both of decreased cost of sickness and of increased productive work. But exhibitions and displays, though they may have their place, form a very small part of the work of health education. The promotion of physical and mental fitness and the prevention of disease are the main tasks of the staff of the Health and Welfare Department. The doctor at the child welfare clinic advising on the problems of bringing up baby, the doctor at the antenatal clinic discussing the hygiene of pregnancy and the emotional readjustments that will be necessitated by the birth cf the child, the health visitor in the home guiding the family as a whole towards a better integration with their environment, the health visitor advising on the immunisation of the infant or on preparation for retirement by the elderly person, the school doctor and nurse inculcating the idea of health maintenance as part of one's duty to oneself and to the community, the sanitary inspector, the district nurse, and even the home help exerting their influence towards the removal of factors and conditions prejudicial to health —these are the people who teach health education, and they can be very greatly assisted by the journalist, the teacher, the clergyman, and the youth leader, provided that such persons are knowledgeable on health matters.

Nevertheless, the set speech, the poster and the leaflet, issued at the appropriate moment, all help. In this connection, it must be recorded that members of the medical and nursing staff have willingly devoted many evenings to addressing organisations, clubs, and societies on health matters; that, at the child welfare clinics, certain sessions are specifically allocated to health education; and that full use is made of the posters and leaflets made available by the Scottish Council for Health Education.

Health is, of course, not merely the absence of disease but a condition of physical, mental, emotional, social, and spiritual well-being. In health education, in the widest sense of these words, lies the greatest hope of conferring benefit on the entire community. The Health and Welfare Department already does much in the way of health education: it must in the future do even more.

STAFF AT 31st DECEMBER, 1952.

Medical Officer of Health	Ian A. G. MacQueen, M.A., M.D., D.P.H.
Depute Medical Officer of Health	Mabel E. Mitchell, B.L., B.Sc., M.D., D.P.H.
Assistant Medical Officer (Schools)	Henry J. Dawson, M.A., M.B., Ch.B., D.P.H.
Assistant Medical Officers	Mary Hunter, M.B., Ch.B., D.P.H. Sarah Lorimer, B.Sc., M.B., Ch.B., D.C.H. Mary A. Montgomery, M.B., Ch.B., B.A.O., D.P.H Margaret Ormiston, M.B., Ch.B., D.P.H. Jean Pattullo, M.B., Ch.B., D.P.H. Marie S. Sutherland, M.B., Ch.B., D.P.H. Doreen G. Warnock, M.B., Ch.B., D.P.H., D.R.C.O. Annie Gartly, M.B., Ch.B., D.P.H. (part-time). 3 Vacancies.
Chief Dental Officer	Edmund G. H. Lightfoot, L.D.S.
Senior Dental Officer	Vacant.
Assistant Dental Officers	Hugh Clunas, L.D.S. John Ogden, B.D.S. Jean L. Rea, L.D.S. 2 Vacancies.
Public Analyst	Alexander B. Weir, B.Sc., A.R.I.C.
Lay Administrative Officer	Colin C. Grainger.
Statistician (part-time)	Vacant.
Superintending Nursing Officer and Supervisor of Midwives	Jane A. Stark, S.R.N., S.C.M., Q.I.D.N.S., Heal Visitor's Certificate.
Assistant Superintending Nursing Officer	Lisetta J. Stephen, S.R.N., S.C.M., Health Visito Certificate.
Health Visitors	65 (including 13 vacancies).
Midwives	8.
Health Visitor Tutor	D. Joan Lamont, S.R.N., S.C.M., Health Visito Certificate, Health Visitor Tutor's Certificate.
Student Health Visitors	20.

Nurseries—

(*a*) Residential—

Pitfodels	Matron—Mary J. Mitchell, S.R.N., 1 Deputy Matron, 2 S Nurses, 2 Certificated Nursery Nurses, 1 Enrolled Assist Nurse, 7 Nursery Assistants, 7 Probationer Student Nurse
Thorngrove	Sister-in-Charge—Margaret C. I. Robertson, S.R.N., S.C.M. Sister, 3 Staff Nurses, 2 Certificated Nursery Nurses, 10 P bationer Student Nurses.

(*b*) Day—

Charlotte Street	Matron—Margaret A. F. Duffton, S.R.N., 1 Deputy Matron, 1 Staff Nurse, 1 Certificated Nursery Nurse, 3 Nursery Assistants, 11 Student Nurses, 1 Probationer Student Nurse.
Linksfield	Matron—Georgina Nicol, R.S.C.N., 1 Deputy Matron, 2 Enrolled Assistant Nurses, 3 Student Nurses, 4 Probationer Student Nurses.
Torry	Matron—Jessie M. Arnott, S.R.N., S.C.M., 3 Certificated Nursery Nurses, 2 Nursery Assistants, 6 Student Nurses.
View Terrace	Matron—Jessie B. Kennedy, S.R.N., S.R.M.N., 1 Deputy Matron, 1 Staff Nurse, 1 Certificated Nursery Nurse, 1 Nursery Assistant, 9 Student Nurses, 3 Probationer Student Nurses.

ld People's Homes—

Balnagask—

Superintendent and Matron	Mr. and Mrs. A. Shirran.

No. 3, Ferryhill Place—

Matron	Mrs. Annabella MacMillan.

nitary Section—

Chief Sanitary Inspector	Francis Thom, Sanitary Inspector's Certificate.
Senior Assistant Sanitary Inspector	Gideon Lawrie, Sanitary Inspector's Certificate.
District Sanitary Inspectors	5.
Assistant District Sanitary Inspectors	7 (including 1 vacancy).
Apprentice Sanitary Inspectors	2 (including 1 vacancy).
Probationer Sanitary Inspector	1.
Shops Acts Inspectors	2.
Senior Detention Officer	William McDonald, Meat Inspector's Certificate.
Detention Officers	3.

elfare Section—

Senior Assistant Welfare Officer	James D. Davidson.
District Welfare Officers	3.

rical—

Senior Clerical Staff	E. B. Catto, Secretary to Medical Officer of Health; M. M. Barry; A. G. Gall; C. P. Gibson; A. E. Munro; M. C. Veitch, M. A. Wilson.
Other Clerical Staff	General, 11; Clinics, 2; Dental Clinic, 1; Sanitary, 3; Welfare, 3.

scellaneous—

Audiometrician	1 (vacant).
Dental Attendants	2.
Male Visitor, School Medical Service	1.
Home Helps	Full-time, 36; Part-time, 39.
Lodging-house Superintendent and Matron	Mr. and Mrs. J. Adam
Drivers and Porters	3.
Rat-catchers	5.